controlled quantity of radioactive materials (HRCQ), as defined in § 173.403(1) of this subchapter, shall operate the motor vehicle only over preferred routes selected by the carrier to reduce time in transit over the preferred route segment of the trip, except that an Interstate System bypass or Interstate System beltway around a city, when available, shall be used in place of a preferred route through a city, unless State routing agency has designated an alternative route.

(1) A perferred route is either of both an Interstate System highway for which an alternative route is not designated by one or more State routing agencies as provided in this section or a State-designated route selected by one or more State routing agencies (see § 171.8 of this subchapter) in accordance with the following conditions:

(i) The State routing agency shall select routes to minimize radiological risk using "Guidelines for Selecting Preferred Highway Routes for Highway Route Controlled Quantity Shipments of Radioactive Materials", or an equivalent routing analysis which adequately considers overall risk to the public. Designations must be preceded by substantive consultation with affected local jurisdictions and with any other affected States to ensure consideration of all impacts and continuity of designated routes.

(ii) State routing agencies may designate preferred routes as an alternative to, or in addition to, one or more Interstate System higways, including an Interstate Systems bypass or an Interstate System beltway.

(iii) A State-designated route is not effective until the State gives written notice, by certified mail, return receipt requested, to, and receipt thereof is acknowledged by, the Dockets Unit (DHM-30), Research and Special Programs Adminsitration, U.S. Department of Transportation, Washington, DC 20590 (Attention: Registry of State-designated Routes, Docket HM-164A). The Dockets Unit will provide a list of State-designated preferred routes upon request.

(2) A motor vehicle may be operate over a route, other than a preferred route, only under the following conditions:

(i) The deviation from the preferred route is necesssary to pickup or deliver a highway route controlled quantity of package of radioactive materials, to make necessary rest, fuel or motor vehicle repair stops, or because emergency conditions make continued use of the preferred route unsafe or impossible;

(ii) For pickup and delivery not over preferred routes, the route selected must be the shortest distance route from the pickup location to the nearest preferred route entry location, and the shortest distance route to the delivery location from the nearest preferred route exist location.

(iii) Deviations from preferred routes, or pickup or deliver routes other than preferred routes, which are necessary for rest, fuel or motor vehicle repair stops; or which are necessary because of emergency conditions, shall be made in accordance with the radiological risk minimization criteria of paragraph (a) of this section unless, due to emergency conditions, time does not permit use of those criteria.

* * * * *

Issued in Washington, DC on September 25, 1989, under authority delegated in 49 CFR part 106, Appendix A.

Alan I. Roberts,

Director, Office of Hazardous Materials Transportation.

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Part VI

Federal Emergency Management Agency

44 CFR Parts 59 and 60

National Flood Insurance Program; Elevation Requirements for Manufactured Homes in Existing Manufactured Home Parks and Subdivisions; Final Rule

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Parts 59 and 60

RIN 3067-AB32

National Flood Insurance Program; Elevation Requirements for Manufactured Homes in Existing Manufactured Home Parks and Subdivisions

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Final rule.

SUMMARY: This final rule revises the National Flood Insurance Program (NFIP) floodplain management criteria that are applicable to the placement or substantial improvement of manufactured homes in existing manufactured home parks and subdivisions in flood hazard areas and also the requirements applicable to recreational vehicles. The final rule replaces provisions of § 60.3(c)(6) that became effective on October 1, 1986, but that were suspended by a notice published in the **Federal Register** on June 30, 1987 (52 FR 24370). That suspension is extended through October 31, 1989 elsewhere in this issue to be consistent with the effective date of this final rule.

EFFECTIVE DATE: November 1, 1989.

FOR FURTHER INFORMATION CONTACT: Michael F. Robinson, Federal Emergency Management Agency, Federal Insurance Administration, 500 C Street SW., Washington , DC 20472; telephone number (202) 646-2717.

SUPPLEMENTARY INFORMATION: On May 19, 1989, FEMA published for comment in the **Federal Register** (54 FR 21889) a proposed rule. This proposed rule contained provisions which would revise NFIP floodplain management criteria on placement and substantial improvement of manufactured homes on sites in existing manufactured home parks and subdivisions. It replaces provisions that became effective on October 1, 1986, but which were subsequently suspended by FEMA in a June 30, 1987 **Federal Register** notice and later by the Supplemental Appropriations Act of 1987 (Pub. L. 100-71). In addition, provisions were included regarding the application of these requirements to certain recreational vehicles.

Prior to developing the proposed rule, FEMA reviewed the comments submitted in response to the June 30, 1987 **Federal Register** notice, conducted further research into the impacts of flooding on existing manufactured home parks and subdivisions, and developed a report for Congress entitled "National Flood Insurance Program: Report on Existing Manufactured Home Parks and Subdivisions". That report concluded that there were alternatives to the October 1, 1986 rule revision that would reduce the adverse economic impacts on the owners and residents of existing manufactured home parks and subdivisions, yet still achieve the NFIP objectives of reducing flood damages and threats to public safety.

After submitting that report to Congress in September of 1988, FEMA met with a task force chaired by the National Manufactured Housing Federation which made additional recommendations to FEMA in February of 1989. The proposed rule contained elements of both the alternative developed by FEMA in its report for Congress and the recommendations of that task force. Further background on the development of the proposed rule and on issues related to the regulation of placement of manufactured homes in existing manufactured home parks located in flood hazard areas and on regulations applicable to recreational vehicles is contained in the supplemental information to the proposed rule.

Copies of the proposed rule were mailed to the nearly 18,000 communities participating in the NFIP and to a number of associations, organizations and individuals which have expressed interest in the issues which the rule addresses. There were 44 comments or letters from 40 different organizations, government units, or individuals. Of those submitting comments, six were local and state agencies, two were owners or operators of recreational vehicle parks, two were owners of operators of existing manufactured home parks and subdivisions, three were owners or operators of recreational vehicle parks, two were owners of combination manufactured home parks and recreational vehicle parks, sixteen were residents of recreational vehicle parks, eight were manufactured housing or floodplain management associations, one was a manufacturer of manufactured homes, one was a manufactured home park resident, and one was an insurance company representative. Note that more than one comment was received from several respondents and that several letters that were sent directly to FEMA during the comment period were placed in the Rules Docket. This number of comments is small relative to the 1,407 comments that were submitted to the Rules Docket established by the June 30, 1987 **Federal Register** notice.

In general, the comments concerning provisions in the proposed rule on existing manufactured home parks and subdivisions were supportive. Most recognized that the rule represents a compromise that is intended to minimize adverse economic impacts on the manufactured home community while at the same time substantially achieving the NFIP objectives of reducing loss of life and property due to flooding. However, many of these comments requested clarifications of various provisions or of specific terms used in the proposed rule or raised issues or questions not fully addressed in the proposed rule. Comments regarding the requirements for recreational vehicles for the most part expressed concerns that no provisions were included to "grandfather" certain recreational vehicle parks which contain park trailers or park models and which are operated in much the same manner as manufactured home parks. This final rule has been developed after consideration of the comments and suggestions received in response to the proposed rule.

Requirements for Existing Manufactured Home parks and Subdivisions

For existing manufactured home parks and subdivisions, the proposed rule contained three basic provisions. First, communities would be required to develop or have developed evacuation plans for residents of existing manufactured home parks and subdivisions. Second, manufactured homes placed or substantially improved on sites in an existing manufactured home park or subdivision on which a manufactured home has incurred substantial damage as the result of a flood would be required to be elevated to or above the base flood elevation. Third, all other manufactured homes placed or substantially improved in these existing manufactured home parks and subdivisions would have to be elevated on reinforced piers or other foundation elements that are no less than 36 inches in height above grade or have their lowest floor at or above the base flood elevation if this allows for the use of a lower foundation.

Evacuation Plans

The first of the three basic provisions of the proposed rule would require that a plan for evacuating the residents of existing manufactured home parks or subdivisions be developed and filed with and approved by appropriate community emergency management authorities. The purpose of this requirement is to reduce the potential

for loss of life if existing manufactured home parks or subdivisions are flooded. This requirement was included in the regulations prior to October 1, 1986. Five comments addressed this requirement. Two manufactured home park owners opposed the requirement due to the time and cost required to develop evacuation plans. Three communities supported the need for evacuation plans, but raised issues regarding the implementation of the requirement. One of the communities asked whether the plans would be required if it continued to require elevation of all manufactured homes, one community requested a one year period to develop the plan, and a third community felt that the requirement was appropriate, but that annual notification of existing manufactured home park residents should also be required.

Upon further consultation with its Regional Office staffs, FEMA has decided to retain the provision, but place it instead in 44 CFR 60.22. "Planning considerations for floodprone areas." While the adoption or implementation of the provisions in § 60.22 are at the option of the community, FEMA recommends that communities adopt or implement any of the provisions that are appropriate given its circumstances. The agency's reason for moving the provision to this section is that the requirement is more appropriately addressed as part of the community's overall comprehensive emergency management plan. These plans are necessary to protect lives and property in the community as a whole and not merely in existing manufactured home parks and subdivisions. FEMA believes that in most communities adequate plans are already in place. FEMA regional staff will be available to provide advice and assistance if any community wishes to develop or modify an emergency plan.

Substantial Damage

The second, and, from the standpoint of reducing future flood losses, the most important of the basic provisions in the proposed rule, is the revised requirement at 44 CFR 60.3(c)(6) that manufactured homes be elevated so that their lowest floors are at or above the base flood elevation when placed on sites in an existing manufactured home park or subdivision where a manufactured home has incurred substantial damage as a result of a flood. Paragraph (c)(6) would also require elevation of manufactured homes placed or substantially improved on sites outside of a manufactured home park or subdivision, in a new manufactured home park or subdivision, or in an expansion to an existing manufactured home park or subdivision. These other sites were subject to the elevation requirement prior to the October 1, 1986 rule revision.

The term "substantial damage" is defined in a final rule which FEMA published in the Federal Register on August 15, 1989 (54 FR 33541). "Substantial damage" means damage sustained by a structure (in this case a manufactured home) whereby the cost of restoring the structure to its before damaged condition would equal or exceed 50 percent of the market value of the structure before the damage occurred. As indicated in the supplemental information to the proposed rule, once a manufactured home has been destroyed or sustained major damage due to a flood on a particular site, there is no justification to further delay imposition of an elevation requirement on that site since the post-flood period provides opportunities to upgrade or relocate sites with fewer impacts due to the disruptions already caused by the flood. In addition, these sites will tend to include those subject to the most severe and frequent flooding.

One comment requested confirmation that the provision only applied to flood damage and not to other types of damage such as fire or wind. This is correct and is specifically stated in the proposed rule. To do otherwise might create practical difficulties where manufactured homes on small scattered lots would have to meet elevation requirements, a situation that the proposed rule sought to avoid where possible.

Three comments concerned how the market value of a manufactured home would be determined for application of the substantial damage requirement. The market value in the "substantial damage" provision is the market value of the manufactured home itself and its foundation and does not include the market value of the land or of other improvements made to the land.

Generally, the nature of the flood damages that occur to manufactured homes will minimize the frequency of problems in making this determination. Manufactured homes which are flooded and sustain other than minor damages often have major structural damages and cannot be repaired. However, if flood damages do approach 50 percent, the determination of market value becomes more critical and use of a qualified appraiser may be required.

The example provided in one of the comment letters is a manufactured home in a particularly desirable rental community which has a market value far in excess of the purchase price and installation costs of the manufactured home. If this manufactured home were located in a manufactured home subdivision, the market value of the manufactured home plus the lot could be determined through looking at comparable sales. The value of the land could also be determined through comparable sales and that amount subtracted to determine a market value for the manufactured home itself. Generally, this market value should approximate the actual cash value of the manufactured home plus the cost of installing a manufactured home on the site. Any added value due to the desirability of the location would be reflected in the market value of the land itself and not the manufactured home located on the land.

If the manufactured home is on a particularly attractive leased site such as the example in the comment letter, the market value of the manufactured home should be determined through comparable sales and the value of the lease subtracted. Again, the market value of the manufactured home should approximate the actual cash value of the manufactured home plus the value of the installation. Much of the high market value of these manufactured homes must be ascribed to the value of the lease or other rights to the location and not to the manufactured home.

One comment requested confirmation that a manufactured home could be repaired without meeting elevation requirements if the damage was less than 50% of market value. This is correct. The elevation requirement would only apply if the criteria in the definition of "substantial damage" were met.

Use of the 36 Inch Reinforced Pier or Other Foundation

The third basic provision in the proposed rule requires that manufactured homes that are placed or substantially improved (for other than substantial damage due to a flood) on sites in existing manufactured home parks or subdivisions in flood hazard areas are elevated so that the manufactured home chassis is supported by reinforced piers or other foundation elements that are no less than 36 inches in height above the grade at the site. A lower foundation system could be used if the lower floor of the manufactured home would be at or above the base flood elevation using such a foundation.

There were four comments regarding this requirement. One local government recommended requiring use of an 18 inch pier since they believe that these

piers are more common and since a 36 inch pier requires proper reinforced footings and additional anchoring. FEMA notes that these manufactured homes are being installed in flood hazard areas. By requiring, at a minimum, a 36 inch reinforced pier or other foundation sytem, additional flood protection can be achieved with minimal impacts on the owners of manufactured homes or on the owners of existing manufactured home parks. This should result in a reduction of flood losses and the resulting flood insurance claims payments and disaster assistance costs.

One comment requested clarification of what FEMA means by "other foundation elements". FEMA does not want to preclude the use of foundations other than reinforced piers. Many of these other foundations may be more resistant to flood forces than a reinforced pier and their use is advisable under many flooding conditions. Examples of these other types of foundation elements include posts, piles, poured concrete or reinforced block foundation walls, or properly compacted fill. Information on these other foundations can be found in the FEMA publication Manufactured Home Installation in Flood Hazard Areas. In response to inquiries raised regarding the proposed rule, FEMA has revised the final rule to read "reinforced piers or other foundation elements of at least equivalent strength". This is intended to make it clear that, when these other foundation elements are used, they must also be capable of resisting flood forces.

One comment requested that FEMA define "reinforced pier" since dry stacked blocks are commonly used to install manufactured homes. This type of foundation is not a "reinforced pier" and would not be an acceptable manufactured home installation in a flood hazard area. A dry stacked block pier foundation is dependent on the weight of the manufactured home to keep the foundation in place and provides very little resistance to flood forces. Under flooding conditions, the manufactured home can become buoyant or the manufactured home and the supporting piers can become subject to lateral flood forces even if anchored with over-the-top of frame ties. This can result in overturning and collapse of the piers and severe damage to the manufactured home.

The word "reinforced" is intended to reemphasize the general requirement that the manufactured home be placed on a permanent foundation and be securely anchored to an adequately anchored foundation system to prevent floatation, collapse or lateral movement of the manufactured home due to flood forces. A reinforced pier is an integral part of this foundation and anchoring system. At a minimum a "reinforced pier" would have a footing adequate to support the weight of the manufactured home under saturated soil conditions such as occur during a flood. In addition, if stacked concrete blocks are used, vertical steel reinforcing rods should be placed in the hollows of the blocks and those hollows filled with concrete or high strength mortar. In areas subject to high velocity floodwaters and debris impact, cast-in-place reinforced concrete piers may be appropriate. The community will have to determine what reinforcement is appropriate given the flooding and debris conditions at the site. The FEMA manual Manufactured Home Installation in Flood Hazard Areas contains further guidance on reinforced pier foundations.

One comment requested that FEMA clarify how the requirement would be applied to a manufactured home installation on a sloping site. Would the 36 inches be measured from the lowest or highest grade on that site? The 36 inches would be measured from the lowest grade since the intent of the provision is to minimize costs by not requiring higher foundations which in some states must be designed by an engineer.

Clarification of Requirements

An association suggested a revised organization of the provisions in 44 CFR 60.3(c) and (e) to clarify the requirements applicable to manufactured homes and recreational vehicles. FEMA agrees that the provisions are complicated and further clarification is desirable. However, it believes that the language recommended by this association would be no clearer than that in the proposed rule. Instead, FEMA has made a number of language changes intended to clarify the requirements.

In the final rule, paragraph (c)(14) on recreational vehicles has been revised by adding the phrase "elevation and anchoring requirements" in the reference to the provisions of (c)(6) to make it clear that the portions of (c)(6) that are being referenced are the performance standards and not the provisions regarding which manufactured homes are subject to those requirements.

Section 60.3(e) in the final rule was revised to clarify which requirements apply to existing manufactured home parks or subdivisions or to recreational vehicles in V-zones. In developing the proposed rule, FEMA had not believed that it was necessary to include these provisions in § 60.3(e) since paragraph (e)(1) includes by reference all requirements in § 60.3(c). However, FEMA agrees that some clarification is warranted. The provision at § 60.3(e)(8) has been modified to specifically state that manufactured homes placed in existing manufactured home parks or subdivisions (except on sites where a manufactured home has been substantially damaged by a flood) are subject to the provisions of (c)(12). Paragraph (e)(9) has been added to clarify the requirements applicable to recreational vehicles placed in V-zones. Recreational vehicles must either be on the site for fewer than 180 consecutive days, be fully licensed and ready for highway use, or meet the requirements for V-zone structures in (e) (2) through (7).

Requirements To Be Applied to Recreational Vehicles

The proposed rule included a separate definition of "recreational vehicle" which was consistent with the definition in U.S. Department of Housing and Urban Development (HUD) regulations and included separate floodplain management requirements for "recreational vehicles" at 44 CFR 60.3(c)(14).

Under the proposed rule, no floodplain management regulations would apply to a recreational vehicle if the recreational vehicle was on site for fewer than 180 consecutive days or was fully licensed and "ready for highway use". "Ready for highway use" means that the recreational vehicle is on its wheels or jacking system, is attached to the site only by quick disconnect type utilities and security devices, and has no permanently attached additions. If the recreational vehicle did not meet either of these criteria, the recreational vehicle would be subject to the permitting requirements in § 60.3(b)(1) and the elevation and anchoring requirements in § 60.3 (c)(6) or (e) (2) through (7) as appropriate.

The proposed rule contained no provisions for "grandfathering" recreational vehicle sites in campgrounds, travel trailer parks, or recreational vehicle parks or resorts. It was believed that generally these sites can continue to be used by recreational vehicles which are "fully licensed and ready for highway use". Those recreational vehicles which are currently on sites and which are not "fully licensed and ready for highway use" would not be subject to these requirements unless they were substantially improved or replaced by

another recreational vehicle. When a recreational vehicle is removed from the site for whatever reason, the owner of the campground, travel trailer park, or recreational vehicle park or resort or the owner of an individual site will have the option of either meeting the floodplain management requirements with any replacement recreational vehicle or ensuring that such a vehicle remained fully licensed and highway ready. The latter alternative is not inconsistent with the manner in which most of these facilities are traditionally operated and should pose no hardship to the owner or operator of that facility.

An additional reason for not "grandfathering" recreational vehicle sites is that most campgrounds, travel trailer parks and recreational vehicle parks or resorts were initially established to serve a transient clientele and only later evolved into permanent placements of individual recreational vehicles on sites. It would not be possible to develop a simple set of criteria for "grandfathering" individual recreational vehicle sites.

A total of 21 comments were received that specifically addressed this provision. Most of these comments were from persons residing in a community in Florida where there are a number of recreational vehicle parks or resorts with sites designed and intended for the permanent placement of park trailers or park models. FEMA understands that in this particular community permanent placement of park trailers or park models in certain of these recreational vehicle parks or resorts is permitted, but the park trailer must be installed on piers, have permanent utility connections, be adequately anchored, and have no additions other than a screen room of prescribed size. Generally, these recreational vehicle parks or resorts do rent some sites on a short term basis. However, the intent of the owners is to eventually lease as many sites as possible for permanent placement or park trailers or park models. Comments indicate that the State of Florida requires park trailers or park models in excess of 400 square feet to meet both American National Standards Institute (ANSI) standards for recreational vehicles and U.S. Department of Housing and Urban Development (HUD) standards for manufactured homes. The argument is made that the only real distinction between these recreational vehicle parks or resorts and nearby manufactured home parks is that one contains manufactured homes and the other contain the somewhat smaller park trailers and park models.

The general thrust of the comments is that those recreational vehicle parks or resorts which are designed or intended for permanent placement of park trailers or park models should be "grandfathered" in the same manner as existing manufactured home parks and subdivisions. Several comments suggested that some form of special procedure be developed to allow for this "grandfathering". FEMA continues to believe that for most recreational vehicle parks and for most communities, the alternative of using the site for recreational vehicles that are fully licensed and ready for highway use is reasonable and consistent with standard recreational vehicle park operations. However, the Agency does recognize that there may be an inequity in the case of recreational vehicle facilities that have been established for the permanent placement of park trailers or park models and whose operations are analogous to those of manufactured home parks.

FEMA has determined that at this time it would be inappropriate to "grandfather" all recreational vehicle parks or resorts since most are not limited to park models or regulated and operated the same as manufactured home parks. However, it will entertain requests from communities for exceptions to this requirement under 44 CFR 60.6(b)(1) of NFIP regulations. This paragraph allows the Federal Insurance Administrator to permit certain exceptions from NFIP criteria if he or she recognizes that, because of extraordinary circumstances, local conditions may render the application of those standards the cause for severe hardship or gross inequity for a particular community. FEMA will consider granting such an exception if the community can demonstrate that it places restrictions on recreational vehicle parks or resorts that are substantially the same as those placed on manufactured home parks. In particular, FEMA will examine the community's installation requirements, limitations on additions, types of recreational vehicles permitted and requirements placed on park operation. If such a request is granted, that community will be permitted to apply the same floodplain management standards to these recreational vehicle parks as are applied to existing manufactured home parks and subdivisions under this final rule.

FEMA also recognizes that the regulation of park trailers or park models by Federal, State and local government continues to evolve. In many ways, the park trailer or park model shares more in common with a manufactured home than with other types of recreational vehicles. At some future date FEMA may determine that it is appropriate to include all or certain categories of park trailers or park models in its definition of manufactured home. However, at this time, the Agency feels that such an action would be premature.

Other Issues

Several comments from States, local government, or associations expressed support for more restrictive requirements such as those in the October 1, 1986 rule revision which required elevation to or above the base flood elevation of all newly placed manufactured homes. A number of these comments are supportive of the proposed rule only to the degree that it represents a compromise position and an improvement over a return to the "grandfathering" provision as it existed prior to October 1, 1986. Several of these States or communities intend to continue to require the elevation of all manufactured homes to or above the base flood elevation. These concerns were addressed in FEMA's report for Congress entitled "National Flood Insurance Program: Report on Existing Manufactured Home Parks and Subdivisions."

One association recommended that FEMA require use of the 36 inch reinforced pier or other foundation in A-zones where FEMA has not developed base flood elevations. Since it is beyond the scope of the proposed rule, this revision cannot be considered at this time. However, in these unnumbered A-zones where no base flood elevations are available, FEMA encourages communities to require use of the 36 inch reinforced pier or other reinforced foundation elements as a means of minimizing flood damages to manufactured homes.

Two comments from owners of manufactured home parks characterized the proposed rule provisions as an effort to confiscate property without compensation and that, as such, claimed that they exposed communities to litigation. Several comments raised perceived practical problems related to elevating manufactured homes to or above the base flood elevation or even on a 36 inch reinforced pier or raised issues regarding accessibility, aesthetics, or the cost of housing. FEMA has addressed these issues either in its report for Congress or in supplemental information to the proposed rule. Although the perception may exist that there will be practical difficulties and

other problems in meeting the various requirements, this must be balanced against the fact that these existing manufactured home parks are located in flood hazard areas, and that protecting lives and property from flood damage must be the paramount concern.

Two comments recommended that some provision be made for insurance coverage on existing manufactured home park infrastructure. NFIP legislation does not currently authorize coverage for infrastructure and provides coverage only for structures and their contents. Coverage for manufactured home park infrastructure could only be provided if the National Flood Insurance Act of 1968 were amended by Congress.

One comment questioned whether coverage under the NFIP's new Master Condominium Policy would be available for manufactured home parks that have been converted to condominium ownership. It would not since that policy is currently limited to certain multi-family residential structures. In addition, the manufactured homes in a condominium manufactured home park are generally individually owned and only the land and amenities are jointly owned.

Impacts on Community Ordinances

Several comments raised questions regarding adoption of this final rule by NFIP participating communities. It is important to emphasize that NFIP criteria are minimum standards that communities must meet in order to participate in the program. The criteria do not preempt State or community authority to adopt more restrictive requirements if they so choose. This is provided for at 44 CFR 60.1(d) which specifically states that more restrictive State and local regulations take precedence over NFIP criteria. No matter what actions FEMA takes regarding existing manufactured home parks and subdivisions, some States and many communities are likely to continue to require standards equivalent to those in the October 1, 1986 rule revision.

Many communities currently have ordinances in effect which contain provisions which are more restrictive than this final rule. These include communities in several States which require that all manufactured homes be elevated to or above the base flood elevation. In addition, these include any community which has adopted and currently has in force the October 1, 1986 elevation requirement. These communities are compliant with this final rule since they have more restrictive requirements in effect. These communities will have the option of incorporating the final rule into their ordinances if they so wish.

In addition, FEMA has determined that any community which does not have an existing manufactured home park or subdivision within its boundaries will also be considered compliant regardless of the language in their ordinance since the "grandfather" provision would have no practical effect. However, these communities will be expected to revise their ordinances to meet or exceed the new requirements the next time they revise these ordinances for any other reason.

Ordinance revisions will be required by FEMA for those communities that both (1) have existing manufactured home parks or subdivisions and (2) have retained or amended their ordinances to reincorporate the complete "grandfathering". These communities will also have to adopt the definition of "substantial damage" from the final rule published in the **Federal Register** on August 15, 1989 (54 FR 33541). NFIP criteria at 44 CFR 60.7 allow communities up to six months from the effective date of any new regulation to revise their floodplain management ordinances to comply with the changes. Since the effective date of this final rule is October 1, 1989, communities must amend their ordinances prior to April 1, 1990 in order to comply with this final rule. Amended ordinances should be submitted to the appropriate FEMA Regional office. If subsequent to that date, FEMA determines that a particular community has not complied with the new requirements, that community will be provided 90 days written notice of suspension from the NFIP. A suspension letter will be sent to the community 30 days prior to the suspension date and notice of the suspension will be published in the **Federal Register**. If the community has not submitted compliant regulations to the appropriate FEMA Regional office prior to the suspension date, it will be suspended from the NFIP. FEMA Regional offices will be available to provide communities with assistance in meeting this requirement.

FEMA has determined, based upon an Environmental Assessment, that the final rule does not have significant impact upon the quality of the human environment. As a result, an Environmental Impact Statement will not be prepared. A finding of no significant impact is included in the formal docket file and is available for public inspection and copying at the Rules Docket Clerk, Office of General Counsel, Federal Emergency Management Agency, 500 C Street SW., Washington, DC 20472.

The final rule does not have a significant economic impact on a substantial number of small entities and has not undergone regulatory flexibility analysis. Note that the basis of this determination is FEMA's report "National Flood Insurance Program: Existing Manufactured Home Parks and Subdivisions", which examined these potential impacts in detail.

The final rule is not a "major rule" as defined in Executive Order 12291, dated February 17, 1981, and hence, no regulatory analysis has been prepared.

FEMA has determined that this final rule does not contain a collection of information requirement as described in section 3504(h) of the Paperwork Reduction Act.

List of Subjects in 44 CFR Parts 59 and 60

Flood insurance, Flood plains.

Accordingly, 44 CFR chapter I, subchapter B is amended as follows:

PART 59—GENERAL PROVISIONS

1. The authority citation for part 59 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978; E.O. 12127.

§ 59.1 [Amended]

2. Section 59.1 is amended as follows:

a. By adding alphabetically, a definition of "Existing manufactured home park or subdivision" to read as follows:

* * * * *

Existing manufactured home park or subdivision means a manufactured home park or subdivision for which the construction of facilities for servicing the lots on which the manufactured homes are to be affixed (including, at a minimum, the installation of utilities, the construction of streets, and either final site grading or the pouring of concrete pads) is completed before the effective date of the floodplain management regulations adopted by a community.

* * * * *

b. By adding alphabetically, a definition of "Expansion to an existing manufactured home park or subdivision" to read as follows:

* * * * *

Expansion to an existing manfactured home park or subdivision means the preparation of additional sites by the construction of facilities for servicing the lots on which the manufacturing homes are to be affixed (including the installation of utilities, the construction

of streets, and either final site grading or the pouring of concrete pads).

* * * * *

c. By revising the definition of "Manufactured home" to read as follows:

* * * * *

Manufactured home means a structure, transportable in one or more sections, which is built on a permanent chassis and is designed for use with or without a permanent foundation when attached to the required utilities. The term "manufactured home" does not include a "recreational vehicle".

* * * * *

d. By adding, alphabetically, a definition of "New manufactured home park or subdivision" to read as follows:

* * * * *

New manufactured home park or subdivision means a manufactured home park or subdivision for which the construciton of facilities for servicing the lots on which the manufactured homes are to be affixed (including at a minimum, the installation of utilities, the construction of streets, and either final site grading or the pouring of concrete pads) is completed on or after the effective date of floodplain management regulations adopted by a community.

* * * * *

e. By adding, alphabetically, a definition of "Recreation vehicle" to read as follows:

* * * * *

Recreational vehicle means a vehicle which is:

(a) built on a single chassis;

(b) 400 square feet or less when measured at the largest horizontal projection;

(c) designed to be self-propelled or permanently towable by a light duty truck; and

(d) designed primarily not for use as a permanent dwelling but as temporary living quarters for recreational, camping, travel, or seasonal use.

* * * * *

PART 60—CRITERIA FOR LAND USE MANAGEMENT AND USE

3. The authority citation for part 60 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978; E.O. 12127.

§ 60.3 [Amended]

4. Section 60.3 is amended as follows:

a. By adding in paragraph (b)(4) between the phases "(c)(5)" and (c)(12)" the phrase "(c)(6)" and between the phrases "(c)(12)" and "(d)(2)" the phrase "(c)(14)".

* * * * *

b. By revising paragraph (c)(6) to read as follows:

* * * * *

(c) * * *

(6) Require that manufactured homes that are placed or substantially improved within Zones A1–30, AH, and AE on the community's FIRM on sites

(i) outside of a manufactured home park or subdivision,

(ii) in a new manufactured home park or subdivision,

(iii) in an expansion to an existing manufactured home park or subdivision, or

(iv) in an existing manufactured home park or subdivision on which a manufactured home has incurred "substantial damage" as the result of a flood, be elevated on a permanent foundation such that the lowest flood of the manufactured home is elevated to or above the base flood elevation and be securely anchored to an adequately anchored foundation system to resist floatation collapse and lateral movement.

* * * * *

c. By adding paragraph (c)(12) to read as follows:

* * * * *

(c) * * *

(12) Require that manufactured homes to be placed or substantially improved on sites in an existing manufactured home park or subdivision within Zones A–1–30, AH, and AE on the community's FIRM that are not subject to the provisions of paragraph (c)(6) of this section be elevated so that either

(i) The lowest floor of the manufactured home is at or above the base flood elevation, or

(ii) The manufactured home chassis is supported by reinforced piers or other foundation elements of at least equivalent strength that are no less than 36 inches in height above grade and be securely anchored to an adequately anchored foundation system to resist floatation, collapse, and lateral movement.

* * * * *

d. By adding paragraph (c)(14) to read as follows:

* * * * *

(c) * * *

(14) Require that recreational vehicles placed on sites within Zones A1–30, AH, and AE on the community's FIRM either

(i) Be on the site for fewer than 180 consecutive days,

(ii) Be fully licensed and ready for highway use, or

(iii) Meet the permit requirements of paragraph (b)(1) of this section and the elevation and anchoring requirements for "manufactured homes" in paragraph (c)(6) of this section.

A recreational vehicle is ready for highway use if it is on its wheels or jacking system, is attached to the site only by quick disconnect type utilities and security devices, and has no permanently attached additions.

* * * * *

e. By removing in paragraph (d)(1) the phrase "(c)(13)" and replacing it with "(c)(14)".

f. By removing in paragraph (e)(1) the phrase "(c)(13)" and replacing it with "(c)(14)".

g. By adding paragraph (e)(8) to read as follows:

* * * * *

(e) * * *

(8) Require that manufactured homes placed or substantially improved within Zones V1–30, V, and VE on the community's FIRM on sites

(i) Outside of a manufactured home park or subdivision,

(ii) In a new manufactured home park or subdivision,

(iii) In an expansion to an existing manufactured home park or subdivision, or

(iv) In an existing manufactured home park or subdivision on which a manufactured home has incurred "substantial damage" as the result of a flood,

meet the standards of paragraphs (e)(2) through (7) of this section and that manufactured homes placed or substantially improved on other sites in an existing manufactured home park or subdivision within Zones VI–30, V, and VE on the community's FIRM meet the requirements of paragraph (c)(12) of this section.

* * * * *

h. By adding paragraph (e)(9) to read as follows:

(e) * * *

(9) Require that recreational vehicles placed on sites within Zones V1–30, V, and VE on the community's FIRM either

(i) Be on the site for fewer than 180 consecutive days,

(ii) Be fully licensed and ready for highway use, or

(iii) Meet the requirements in paragraphs (b)(1) and (e) (2) through (7) of this section.

A recreational vehicle is ready for highway use if it is on its wheels or jacking system, is attached to the site only by quick disconnect type utilities and security devices, and has no permanently attached additions.

§ 60.22 [Amended]

4. Section 60.22 is amended by adding paragraph (c)(19) to read as follows:

* * * * *

(c) * * *

(19) Requirement that a plan for evacuating residents of all manufactured home parks or subdivisions located within flood prone areas be developed and filed with and approved by appropriate community emergency management authorities.

Dated: September 21, 1989.

Harold T. Duryee,

Federal Insurance Administrator.

[FR Doc. 89-22894 Filed 9-28-89; 8:45 am]

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Friday
September 29, 1989

Part VII

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405, 412, and 413
Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405, 412, and 413

[BPD-375-F]

RIN 0938 AC27

Medicare Program; Changes in Payment Policy for Direct Graduate Medical Education Costs

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule.

SUMMARY: This rule sets forth changes in Medicare policy concerning payment for the direct graduate medical education costs of providers associated with approved residency programs in medicine, osteopathy, dentistry, and podiatry. These changes implement section 1886(h) of the Social Security Act, which was added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 and amended by section 9314 of the Omnibus Budget Reconciliation Act of 1986. Also, we are making a conforming change that affects the indirect medical education payments of hospitals that became subject to the prospective payment system during the period October 1, 1983 through December 31, 1983.

DATE: This final rule is effective October 30, 1989.

FOR FURTHER INFORMATION, CONTACT:

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Bernadette Schumaker (ESRD exception criteria), (301) 966-4568.

SUPPLEMENTARY INFORMATION:

I. Background

Medicare has historically paid a share of the net cost of approved medical education activities. Our regulations at 42 CFR 413.85(b) currently define approved educational activities to mean formally organized or planned programs of study usually engaged in by providers in order to enhance the quality of care in an institution. These activities include approved training programs for physicians, nurses, and certain paramedical health professionals (sometimes referred to as allied health professionals), for example, physical therapists. The allowable costs of these activities include the direct costs of salaries and fringe benefits of interns and residents, salaries attributable to the supervisory time of teaching physicians, other teachers' salaries, and the indirect costs (that is, institutional overhead, for example, employee health and welfare benefits) that are appropriately allocated to the particular medical education cost center.

The Medicare program has shared in the costs of approved medical education activities, as defined above, on a reasonable cost basis. Section 1861(v)(1)(A) of the Social Security Act (the Act) defines reasonable cost as the cost actually incurred, excluding any cost unnecessary in the efficient delivery of needed health services to Medicare beneficiaries. Section 413.85 of the regulations further specifies that the allowable cost of approved educational activities is the net cost, which is determined by deducting tuition revenues from total costs.

Under sections 1886 (a)(4) and (d)(1)(A) of the Act, and § 412.113 of the regulations, direct medical education costs are excluded from the definition of operating costs and, accordingly, are not included in the calculation of payment rates under the prospective payment system for inpatient hospital services or in the calculation of the target amount for hospitals excluded from the prospective payment system and subject to the rate-of-increase ceiling. These costs are separately identified and "passed-through," that is, paid on a reasonable cost basis.

We also note that section 1886(d)(5)(B) of the Act and § 412.115(b) of our regulations specify that hospitals with "indirect costs of medical education" will receive an additional payment amount under the prospective payment system. As used in section 1886(d)(5)(B) of the Act, "indirect costs of medical education" means those additional operating (that is, patient care) costs incurred by hospitals with graduate medical education programs. The indirect costs of medical education might, for example, include added costs resulting from an increased number of tests ordered by residents as compared to the number of tests normally ordered by more experienced physicians. (For the regulations governing the determination of indirect medical education costs, see § 412.118.)

Generally, except for hospitals whose first cost reporting period began during the period October 1, 1983 through December 31, 1983, this rule will not apply to indirect medical education payments. It also will not apply to the costs of approved nursing and allied health training programs. It will apply only to the costs associated with approved medical, osteopathic, dental, and podiatric residency programs as currently governed by § 413.85. We are adding a new § 413.86 that will govern approved medical, osteopathic, dental, and podiatric residency programs. In order to avoid confusion, we use the term "direct graduate medical education costs" to refer to the costs of the activities governed by the new § 413.86. We are also making conforming changes to § 413.85. However, none of these changes represents policy changes with regard to the reasonable cost reimbursement of approved nursing and paramedical training programs.

This rule will apply to direct graduate medical education (GME) costs in all hospitals and hospital-based providers and subproviders. Although providers other than hospitals may participate in approved GME programs that Medicare supports, the majority of these programs are concentrated in hospitals and health care complexes. The latter are complexes that include, in addition to a hospital, subproviders such as psychiatric units and other hospital-based providers such as skilled nursing facilities or home health agencies. The allowable costs of GME on which the per resident amounts established by this rule are based include GME costs attributable to nonhospital portions of a health care complex. These costs are not separable in such a manner as to permit per resident amounts based exclusively on the GME costs of the hospital. For example, it would not be unusual for a resident in family practice to see patients in both the acute care portion of a hospital and in the hospital-based skilled nursing facility on his or her daily rounds. To require a tracking of a resident's time in each entity of the hospital complex would not be practical.

In this document, for ease of reference, we will use the term hospital to refer to the institutions to which this rule applies, that is, both hospitals and hospital-based providers and subproviders.

A. The July 1985 Final Rule

In a final rule published in the Federal Register on July 5, 1985 (50 FR 27722), we modified § 413.85 (formerly § 405.421(a)(2) but redesignated on September 30, 1986 (51 FR 34790)) to revise our method of paying for allowable direct medical education costs by imposing a 1-year limit on these costs. Under that final rule, for cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986, a provider's allowable direct medical education costs were to have been limited, under the authority of section 186(v)(1)(A) of the Act, to the lesser of the provider's actual cost of its program or programs for that particular cost reporting period or the provider's allowable costs incurred during a base period (the provider's cost reporting period that began on or after October 1, 1983 but before October 1, 1984).

B. Public Law 99-272

Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272) enacted on April 7,

1986 set forth new provisions, generally effective for cost reporting periods beginning on or after July 1, 1985, for Medicare payment of direct GME costs. One of these provisions, added a new section 1861(v)(1)(Q) of the Act which, in effect, nullified the July 1985 final rule. Section 9202 of Public Law 99–272 also added a new section 1886(h) of the Act, which is effective for cost reporting periods beginning on or after July 1, 1985. Consequently, the provisions of this final rule will be applied retroactively to cost reporting periods beginning on or after July 1, 1985. It applies to all hospitals, whether or not they are subject to the prospective payment system. As an interim step, pending issuance of this final rule, we informed the public in the Federal Register of May 6, 1986 (51 FR 16776) that the July 1985 final rule had been rescinded.

Section 9202 of Public Law 99–272 and its accompanying conference report established two distinct components of the direct medical education pass-through that are used in determining Medicare payment for the costs of approved educational activities—

- Nursing and paramedical health professional (allied health) programs; and
- Graduate medical, osteopathic, dental, and podiatric residency programs.

The statutory language of section 1886(h) of the Act, as enacted by Public Law 99–272, does not specifically address Medicare payment for the costs of approved nursing and paramedical health professional programs. However, the conference report accompanying Public Law 99–272, (H.R. Rep. No. 453, 99th Cong., 1st Sess. 484 (1985)) indicates that the Medicare program will continue to pay hospitals for the direct medical education costs associated with nursing and allied health training activities. In addition, section 1861(v)(1)(Q) of the Act, as added by section 9202(i) of PubLic Law 99–272, prohibits the Secretary from limiting the rate of increase on allowable costs of approved medical education activities other than as explicitly authorized by statute. Thus, section 9202 of Public Law 99–272 does not establish a new payment methodology regarding Medicare's payment for approved nursing and paramedical health professional programs. The effect of section 1861(v)(1)(Q) of the Act and the conference report, as cited above, is to restore the Medicare payment policy for these costs to the policy that existed prior to the publication of the July 1985 rule. Medicare will continue to pay a share of the allowable costs of approved nursing and paramedical health professional programs using Medicare's principles of reasonable cost reimbursement.

In this final rule, we have removed the provisions of current paragraph (a)(2) from § 413.85 since section 9202(i) of Public Law 99–272 has overturned the limitation set forth in this paragraph. We are also revising § 413.85(e) to make changes to the list of the approving bodies for certain nursing and paramedical programs. These changes will conform the regulations to existing policy, as described in chapter 4 of the Provider Reimbursement Manual (HCFA Pub. 15–1).

Section 1886(h) of the Act revises the method for calculating Medicare payment for the direct costs of approved GME activities effective for cost reporting periods beginning on or after July 1, 1985. Section 1886(h) of the Act requires the calculation of hospital-specific approved per resident amounts for each hospital, which are to be determined based on the hospital's allowable costs for its cost reporting period beginning during Federal fiscal year (FY) 1984 (that is, cost reporting periods beginning on or after October 1, 1983 and before October 1, 1984). For most hospitals, that cost reporting period was their first period under the prospective payment system. For cost reporting periods beginning on or after October 1, 1983 but before July 1, 1984, the average per resident amounts will be updated by the Consumer Price Index in order to reflect inflation occurring in the intervening cost reporting period between the base period and the first cost reporting period to which the new methodology would apply. There would be no update factor applied to cost reporting periods beginning from July 1, 1984 through September 30, 1984, since there is no intervening period between the base period and the first period to which the new methodology applies.

For cost reporting periods beginning on or after July 1, 1985 (that is, the first cost reporting period to which section 1886(h) of the Act applies), the per resident amount determined for the base period (that is, cost reporting periods beginning on or after October 1, 1983 but before October 1, 1984) is to be updated by one percent. For subsequent periods, the per resident amounts are to be updated annually based on changes in the Consumer Price Index.

The updated per resident amount is to be multiplied by the weighted average number of full-time equivalent (FTE) residents in an approved program working in the hospital during the cost reporting period to obtain an aggregate approved amount. (As explained below, effective July 1, 1987, the time residents spend in patient care activities outside the hospital setting will also be counted for purposes of determining FTEs if the hospital incurs all or substantially all of the training costs in the outside setting.) Two weighting factors are involved. The first weighting factor to be used is to apply an overall limitation on the number of years that a resident may be counted as an FTE in calculating aggregate approved amounts. This limitation is to be based on an initial residency period (that is, the minimum number of years necessary to achieve board eligibility in a specialty plus 1-year) not to exceed 5 years. Participation for up to 2 years in certain programs in geriatrics will not be counted in determining this limitation. Residents who are no longer in initial residency periods are to be counted as 1.00 FTE prior to July 1, 1986, .75 FTE beginning July 1, 1986, and .50 FTE beginning July 1, 1987.

A second weighting factor to be applied is one regarding residents who are graduates of foreign medical schools. Prior to July 1, 1986, these residents are counted as 1.00 FTE. Effective July 1, 1986, residents who are graduates of foreign medical schools will not be counted at all unless they have passed the Foreign Medical Graduate Examination in Medical Science (FMGEMS) or have received certification from or have previously passed the examination of the Educational Commission for Foreign Medical Graduates. However, section 1886(h)(4) of the Act provides a 1-year transition period (July 1, 1986 through June 30, 1987) for residents who do not meet one of the above qualifying criteria but were in an approved program prior to July 1, 1986. During this 1-year period, these residents will be counted at a rate equal to one-half of the rate at which they would otherwise be counted.

Section 1886(h) of the Act provides that the aggregate approved amount is to be multiplied by the proportion of Medicare hospital inpatient days to total hospital inpatient days in order to determine Medicare's share of direct GME costs. Medicare's share of the costs is then to be apportioned between Medicare's Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance) in such a manner as reasonably reflects the GME costs associated with the provision of services under each part.

Section 1886(h)(2)(E) of the Act provides that if a hospital did not have an approved GME program or did not

participate in Medicare for its cost reporting period beginning in FY 1984, then the Secretary is to determine an appropriate per resident amount.

C. Public Law 99–509

Section 9314 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509), enacted on October 21, 1986, added section 1886(h)(4)(E) to the Act to allow a hospital, for purposes of determining FTEs, to count the time residents spend in patient care activities outside the hospital setting if the hospital incurs all or substantially all of the training costs in the outside setting. This change is effective as of July 1, 1987.

To implement both this legislative change and the changes made by Public Law 99–272, on September 21, 1988, we published a proposed rule in the **Federal Register** (53 FR 36589). In that document, we proposed to add a new § 413.86 that would deal with payment for GME costs and to revise § 413.85 for the purpose of making conforming changes. Our specific proposals are discussed in detail below.

II. Provisions of the Proposed Rule

A. Removal of Limit on Costs

As discussed above, section 1861(v)(1)(Q) of the Act prohibits the Secretary from imposing limits on the rate of increase on allowable costs of medical education other than as explicitly prescribed by law. Currently, § 413.85(a)(2) of the regulations imposes a limit on providers' net costs of approved educational activities for cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986. In order to comply with this statutory prohibition on limits, we proposed to remove the current paragraph (a)(2) from § 413.85.

B. Medicare Payment for Approved GME Programs

Section 1886(h) of the Act establishes a new methodology that is to be used for the purpose of determining Medicare's payment for the part of the direct medical education pass-through attributable to approved GME programs (that is, programs for training interns and residents, hereinafter referred to as residency programs) in medicine, osteopathy, dentistry, or podiatry. Section 9202(b) of Public Law 99–272 specifies that this new methodology is to apply to cost reporting periods beginning on or after July 1, 1985.

The new methodology provides for the determination of a hospital-specific base-period per resident amount to be calculated by dividing a hospital's allowable costs of graduate medical education for a base period by its number of interns and residents in the base period. The base period is the cost reporting period beginning in FY 1984 (that is, the period October 1, 1983 through September 30, 1984). We proposed to update the hospital-specific base-period amount yearly as described below.

The updated base-period per resident amount would be multiplied by the hospital's weighted number of FTE residents during each cost reporting period beginning on or after July 1, 1985 to determine an aggregate approved amount for the period. The aggregate approved amount would represent the basis for Medicare's support of approved residency programs for the period, with no consideration given to actual costs incurred for these programs during a cost reporting period. Medicare's share of the aggregate approved amount would be determined by the Medicare patient load as measured by the ratio of Medicare hospital inpatient days to total hospital inpatient days, and would be apportioned between Part A and Part B based on the ratio of Medicare's share of reasonable costs, excluding GME costs, attributable to each part.

1. Determining Base-Period per Resident Amounts

a. *Methodology.* We proposed to determine an average FTE per resident amount for each hospital during its base cost reporting period. This hospital-specific average FTE per resident amount would be determined based on data reported on the cost reports for that base period with respect to direct GME costs and the number of residents. Thus, we would determine the base-period per resident amount for each hospital by dividing the allowable GME costs for the hospital's cost reporting period beginning in FY 1984 by the number of FTE residents (exclusive of those employed to replace nonphysician anesthetists) reported by the hospital on its cost report for that cost reporting period. (Under the provisions of § 413.85(d)(7), the cost of interns and residents in anesthesiology who are employed to replace nonphysician anesthetists are excluded as approved educational costs since they are not costs for the actual operation of an approved education program.)

In establishing the base-period per resident amount for a specific hospital based on FY 1984 GME costs, it is important that the amount determined be an accurate reflection of legitimate GME costs incurred during the FY 1984 base period. Because the payment methodology required by section 1886(h) of the Act sets future payments using the FY 1984 base-period amounts as the initial starting point, we believe that it is very important that inappropriate costs not be included in the base-period amount. Therefore, we proposed to instruct Medicare contractors to reexamine FY 1984 GME costs and to request appropriate supporting documentation in those cases in which reported costs seem questionable.

Generally, we believe that this review activity would be limited to hospitals and health care complexes that claimed either direct GME costs or indirect medical education payments for cost reporting periods beginning in FY 1984. Cost reports should be amended to remove nonallowable and misclassified costs from the GME base-period costs used to establish per resident amounts. We proposed to initiate this review and reaudit activity prior to the publication of the final rule, so that as soon as possible after the publication of final rule, intermediaries would be able to notify hospitals of their base-period per resident amounts. We did not propose any specific time schedules for this activity, however, in view of the significant other tasks that have been placed on Medicare contractors.

Hospitals whose base-period GME costs appear to be in order would be notified of their base-period per resident amounts. We proposed that hospitals could appeal this determination within 180 days of the later of their receipt of this notice concerning their per resident amounts or of receipt of an original or revised Notice of Program Reimbursement for the GME base period. All appeals of per resident amounts must be appeals of the FY 1984 GME costs or resident counts used in the per resident amount determination. Section 1886(h) of the Act specifies that period as the base-period for determination of such amounts. In other words, a hospital could not appeal its base-period per resident amount in connection with an appeal for the cost reporting period beginning July 1, 1985 or later.

For teaching hospitals whose base-period GME costs appear to include misclassified or nonallowable costs or whose per resident amounts appear to be unreasonably high or low, we proposed that intermediaries will notify these hospitals that their base-period costs will be reaudited. During the reaudits, hospitals would have an opportunity to present documentation of any factors that should be taken into account in the final determination of their base-period per resident amounts. If the basis for the disallowance of costs

from the base-period GME costs is nonallowability, rather than the misclassification of costs, we proposed that recoupment of overpayments should be made for cost reporting periods beginning in FY 1984 and any prior or subsequent cost reporting period in which similar circumstances exist and which may still be reopened under the limitations of § 405.1885.

A hospital whose base-period GME costs are reduced because of a misclassification of operating costs as GME costs may want to reexamine the classification of the affected costs in its prospective payment system base year and request revisions to the prospective payment base-year cost report. If the costs in question were similarly treated in the prospective payment base year, the hospital may want to receive the benefit of consistent treatment of the costs in question as operating costs for the purpose of adjusting its hospital-specific rate (HSR) due to the treatment of GME costs. We proposed that a hospital's cost report for the prospective payment system base year that may no longer be reopened under § 405.1885 may, nevertheless, be reopened but only for the sole purpose of adjusting its HSR for the misclassified GME costs. This adjustment would be based on a recalculation of the hospital's prospective payment system base-year costs. However, no overpayment would be recovered or underpayment paid for the prospective payment system base-year costs if the hospital's cost report for its prospective payment system base year is no longer subject to reopening under § 405.1885. The modification of the prospective payment system base-year costs would be used solely to adjust the hospital's HSR for cost reporting periods under the prospective payment system.

Under § 405.1885, there is a 3-year restriction on reopenings of settled cost reports. We proposed to create a special exception to this time limit so that a hospital could request an adjustment to its HSR. The hospital must request this special reopening within 180 days of the notice to the hospital by the intermediary of the hospital's GME base-period per resident amount. The hospital would bear the burden of proof to document the appropriate treatment of the costs in the prospective payment base year. If the hospital can demonstrate to the satisfaction of the intermediary that this change should be made, the intermediary would appropriately modify retroactively the hospital's base-year cost report used to determine the HSR with respect to operating costs misclassified as GME. As proposed, this modification would be a special exception to our policy concerning retroactive modification of the prospective payment system base-year costs, as specified in §§ 412.71 and 412.72. (That policy is that an intermediary's original estimate of the HSR for purposes of the prospective payment system may not be revised unless the estimate was erroneous based on information available to the intermediary at the time of the estimate.)

In the proposed rule, we emphasized that this policy change is a one-time modification, solely for purposes of calculating GME costs. This change is necessary to properly implement section 1886(h) of the Act, which prescribes the new GME payment methodology. In addition, § 412.113(b) requires that the allowable costs involved in setting the HSR should be recognized consistently as either GME costs or operating costs through the prospective payment system transition period.

This proposed policy change relating to the prospective payment system base-year costs that are used to establish the HSR would be limited to inpatient operating costs that were misclassified as GME costs. Any adjustments to the HSR that are made as a result of this proposed policy change could not include other elements of costs that may have been omitted from the original determination of a provider's HSR.

If a hospital similarly misclassified any of its GME costs as operating costs in the GME base period, the methodology prescribed in section 1886(h) of the Act would preclude this hospital from receiving Medicare payment for the misclassified GME costs. Therefore, in these situations, we again proposed that, if a hospital wants the benefit of the appropriate classification of these legitimate GME costs for the purpose of determining its per resident amount, and if the hospital's cost report for the prospective payment system base year is no longer subject to reopening under § 405.1885, the cost report may nevertheless be reopened. The hospital would need to present its intermediary with sufficient evidence in order to satisfy the intermediary that a change in classification of costs is necessary. If the intermediary is satisfied that such a change is appropriate, the intermediary would adjust the hospital's HSR and recompute the per resident amount in order to reflect the change.

We further proposed that any hospital requesting such a change would have to accept the consequences of a reduced HSR retroactive to the first cost reporting period subject to the prospective payment system. A hospital that believes its FY 1984 GME costs were inappropriately low based on misclassification of GME costs as operating costs would have up to 180 days after notification by its intermediary of its base-period per resident amount to present this additional information. This special reopening provision would be available to hospitals for the sole purpose of correcting a misclassification of GME costs as operating costs.

In both of the above situations involving the adjustment of HSRs, the action is taking place at the request of the hospital or health care complex to mitigate certain negative, though unintended, results of the enactment of section 1886(h) of the Act. Therefore, we proposed that, notwithstanding the provisions of § 405.1885 (a) and (c), all cost reporting periods beginning with the period that served as the prospective payment base year that are no longer subject to reopening may nevertheless be subject to this special reopening. The practical implication of this proposal is to permit reopening in some cases and for a limited purpose after the usual 3-year limitation on reopening of settled cost reports. We emphasized that this special reopening procedure would apply only at the request of the hospital and only to operating costs misclassified as GME costs or GME costs misclassified as operating costs. All other elements of the Medicare cost reports for the years in question would remain settled.

We proposed to use the number of residents reported on the FY 1984 cost report under indirect medical education payment rules as the denominator in calculating base-period per resident amounts. Because of the enactment of section 1886(h) of the Act, we also proposed to modify the criteria governing the counting of interns and residents in approved programs for those hospitals that first entered the prospective payment system during the period October 1, 1983 through December 31, 1983. For these hospitals, we proposed to use the counting criteria adopted in the January 3, 1984 prospective payment rule (49 FR 234) for the purpose of calculating the base-period per resident amount.

The September 1, 1983 interim final rule that implemented the prospective payment system provided that, in calculating the ratio of interns and residents to inpatient hospital beds, a prospective payment system hospital could count only those interns and residents in approved programs that

were employed by the hospital and who furnished services at that hospital (48 FR 39829). However, in the final rule published January 3, 1984, we modified this policy as a result of the comments received on the interim final rule. As discussed in the preamble of that final rule (49 FR 268), we changed our counting policy to allow hospitals to include in their indirect GME intern and resident count, those residents employed by an organization with a long-standing historical medical relationship with the hospital. The organization had to be the sole employer of substantially all of the interns and residents furnishing services at the hospital. This change was effective for cost reporting periods beginning on or after January 1, 1984. This prospective application of the revised policy was determined to be appropriate at that time because of the prospective nature of the prospective payment system.

Because we believe that there is a genuine program interest in using a uniform counting method for purposes of determining per resident amounts, we proposed to adopt the policy of counting interns and residents that was described in the January 3, 1984 prospective payment final rule retroactively to the onset of the prospective payment system. We would include in a hospital's indirect GME count those interns and residents employed by an organization that has a longstanding relationship with a hospital to furnish substantially all of the hospital's residents. This proposed policy would apply to all hospitals that entered the prospective payment system in FY 1984.

If a hospital's base period reflects GME costs for a period other than a full year, we proposed that the intermediary would convert the allowable costs for the base period to a monthly figure and multiply this figure by 12 in order to derive the approved per resident amount for a 12-month cost reporting period. This adjustment to costs would be permissible only if either—

- The length of the base period cost reporting period is shorter than 50 weeks or longer than 54 weeks; or
- The hospital's GME program began after the first month of the hospital's base period.

If a hospital has more than one cost reporting period beginning during FY 1984 (because of a short cost reporting period), we proposed that the latest period would serve as the base period since it is likely that it is more representative of future GME costs. If the latest period is also a short period, allowable GME costs would also be converted to a monthly figure and multiplied by 12 as discussed above.

Section 1886(h)(2)(B) of the Act requires that, for hospitals whose cost reporting periods began between October 1, 1983 and June 30, 1984, the amount derived for the base year be updated by the percentage increase in the Consumer Price Index (CPI) between the hospital's cost reporting period that began during FY 1984 (the GME base period) and the first cost reporting period to which this provision applies. In making this adjustment, we proposed, as discussed in the conference agreement that accompanied section 9202 of Public Law 99–272, (H. R. Rep. No. 453, 99th Cong., 1st Sess. 484 (1985)), to use the Consumer Price Index for All Urban Consumers (CPI–U), a generally accepted measure of inflation. However, if the hospital's base-period cost reporting period began on or after July 1, 1984 and before October 1, 1984, updating is not necessary since the base period occurred immediately prior to the first cost reporting period to which this provision would apply.

The base-period costs would be updated using an inflation factor tied to the month that the cost reporting period began. Included below are the updating factors that we proposed to use. The CPI–U factors shown below apply only to 12-month periods that begin and end in the same month for both years. If this is not the case, we proposed that intermediaries contact HCFA Central Office as to the appropriate factor to use.

Cost reporting period	Update factor*—percent
10/1/83 to 9/30/84	4.20
11/1/83 to 10/31/84	4.03
12/1/83 to 11/30/84	3.95
1/1/84 to 12/31/84	3.57
2/1/84 to 1/31/85	3.52
3/1/84 to 2/28/85	3.74
4/1/84 to 3/31/85	3.66
5/1/84 to 4/30/85	3.75
6/1/84 to 5/31/85	3.73

* The inflation factor represents the 12-month average change in the CPI–U during the intervening period between the provider's base period and the first cost reporting period beginning on or after July 1, 1985.

b. *Updating for cost reporting periods that begin from July 1, 1985 through June 30, 1986.* As required by section 1886(h)(2)(C) of the Act, we proposed to increase the base-period FTE amount, discussed above, by one percent (that is, multiplied by 1.01) for purposes of determining the approved per resident amount applicable to the hospital's cost reporting period that began on or after July 1, 1985 but before July 1, 1986.

c. *Updating for cost reporting periods that begin on or after July 1, 1986.* Section 1886(h)(2)(D) of the Act states that, for subsequent cost reporting periods (that is, those beginning on or after July 1, 1986) "* * * the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index." We proposed to use the CPI–U to implement this provision. Thus, for cost reporting periods beginning on or after July 1, 1986, the FTE resident amount would be determined by applying the 12-month average change in the CPI–U to the per resident amount applicable in the previous cost reporting period. The 12-month average change in the CPI–U represents inflation through the midpoint relative to 12 months earlier.

We proposed that the intermediary use the projected percentage change for interim payment purposes only and adjust the final settlement amount based on the actual average CPI–U percentage change for the months comprising the cost reporting period. The reference to overestimations and underestimations is necessary for purposes of interim payments since the actual inflation rate is not known in advance. However, the actual inflation rate generally becomes available shortly after the end of the cost reporting period and thus the actual rate would be used for settlement purposes. Also, it will be necessary for providers to notify intermediaries of their best estimates of the average number of resident FTEs that should be counted for the cost reporting period for purposes of interim payments.

d. *Per resident amounts for certain Hospitals.* Section 1886(h)(2)(E) of the Act requires us to provide a method for determining an appropriate per resident amount for "* * * a hospital that did not have an approved medical residency training program or was not participating in * * *." Medicare during a cost reporting period that began on or after October 1, 1983 and before October 1, 1984.

In order to implement this provision, we proposed that a hospital's intermediary would establish an average per resident amount for the hospital based on the lower of—

• The actual direct graduate medical education costs of the hospital during its first year of operation of a GME program; or

• The mean value of per resident amounts of hospitals located in the same wage area, as that term is used for purposes of the prospective payment system in §§ 412.62 and 412.63, for cost reporting periods beginning in the same fiscal year.

The intermediaries would determine an average per resident amount for these hospitals based on the hospital's actual cost for the first cost reporting period during which residents were on duty in their GME program during the first month of the cost reporting period. For the purpose of this calculation, we proposed that residents would be counted in the same way as they would for all other hospitals (see description of counting methodology in section II.B.4 of this final rule) except that the weighting factors would not be applied. The intermediary would compare this amount with the mean value of per resident amounts of other teaching hospitals located in the same wage area (as that term is used in the prospective payment system) for cost reporting periods beginning in the same fiscal year. The intermediary would then base its payment on the lower of these amounts (that is, actual per resident amount based on actual allowable costs for the first year, or per resident amounts of other teaching hospitals in the same wage area). If there are fewer than three amounts in the wage area, we proposed that the intermediary write HCFA Central Office for a determination of the per resident amount to use. The per resident amount used for the first year would be updated in future years without regard to actual costs.

The proposed rule further specified that this provision would not be applied to hospitals that expand existing programs or that establish residency programs in additional specialties during the base period. It also would not apply to certain hospitals in States that were formerly paid under a waiver from the Medicare inpatient hospital prospective payment system that incurred GME costs but did not allocate these costs to the intern and resident cost center. (See the discussion in section II.B.10. of this final rule, below).

2. Determining Full-Time Equivalency (FTE)

Section 1886(h)(4) of the Act bases payment for direct GME costs on a hospital's number of full-time equivalent (FTE) residents multiplied by a hospital-specific per resident amount. Since our main concern in the counting of residents is that no individual be counted as more than one FTE, we did not propose to define a FTE based on a specific number of hours worked per week or per year. Rather, we proposed that FTE status would be based on the total time necessary to fill a residency slot.

As proposed, the number of hours involved would vary from specialty program to specialty program within a hospital and could vary from hospital to hospital for the same type of program. For example, if a resident spends all of his or her time in one hospital and is considered by the approved residency program to meet all the requirements of a full-time resident, the resident would always be counted as one FTE (before application of any applicable weighting factors). However, if a resident spends time in more than one hospital, that resident would not be counted as one FTE for either hospital regardless of the actual hours worked. Rather, we proposed that resident's time should be prorated between or among the hospitals to total no more than one FTE.

Section 1886(h)(4)(B) of the Act requires us to take into account, in determining FTEs, individuals who serve as part-time residents. We proposed to count these part-time residents based on the proportion of time worked as compared to the average time spent by others in the same year working in the same specialty program. For example, if a part-time resident spends only sixty percent of the time spent by others in the same program, the part-time resident would be counted as .6 FTE. Similarly, in situations in which two residents "share" one residency slot, no more than one FTE would be counted for the two individuals for the duration of the shared residency. As discussed in the proposed rule, neither of the above policies would apply to full-time residents who spend time sequentially, in more than one hospital. They also would not apply to a full-time resident who drops out of a program. In both of these cases, the individuals are considered full-time residents whose assignments to hospitals would be prorated on a monthly basis.

In determining resident FTEs, we proposed that we would first determine whether the resident is to be counted by the hospital at all. Accordingly, we argued that it was appropriate not to include in a hospital's resident FTE count those residents for whom no hospital participating in Medicare incurs salary/stipend and fringe benefit costs, such as residents in Veterans Administration or Department of Defense programs who are on rotation at civilian hospitals and whose salaries or stipends are fully paid by those respective Federal entities.

We also proposed to prorate FTEs based on the time spent among hospitals by individual residents on a monthly basis. When resident rotations to hospitals are for periods of time other than monthly segments, we proposed that the hospital in which the resident spent the majority of the month will receive full credit for the month and the other hospitals will receive no credit for that month.

Residency programs are based in hospitals in some cases and in medical schools with affiliated hospitals in others. Although the information on the counting of residents must come from the teaching hospitals claiming payment, we argued that it would be helpful, and facilitate payment, if program officials would voluntarily furnish the requisite data on resident assignments to all hospitals involved. The hospitals could then verify the accuracy of their respective FTE count and retain the information for review by the intermediary as needed.

In order to ensure that all residents are properly counted and that no resident is counted as more than one FTE, we proposed to require that each hospital maintain and have available the following information for each resident whom it counts toward its number of FTEs:

• The name and social security number of the resident.

• The type of residency program in which the resident participates and the number of years the resident has completed in all types of residency programs.

• The dates the resident was assigned to the hospital during the cost reporting period.

• The dates, if any, the resident was assigned to other hospitals.

• The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and date of graduation.

• In the case of graduates of foreign medical schools, the resident's status concerning the Foreign Medical Graduate Examination in the Medical Sciences, or certification by the Education Commission for Foreign Medical Graduates, and the appropriate date.

We proposed that this information be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

3. Counting Residents in Nonprovider Settings

Prior to July 1, 1987, the time a resident spends in nonprovider settings (that is, settings that are not considered part of a provider for Medicare purposes) is not counted toward a hospital's FTE count. For example, if the normal GME program commitment for a third-year resident in Family Practice at Hospital A is 80 hours per week and a resident spends 20 of those hours per week in a freestanding family practice clinic, that resident is counted as .75 FTE in Hospital A's count.

Effective July 1, 1987, in accordance with section 1886(h)(4)(E) of the Act, we proposed to count the time a resident spends in nonprovider settings if there is a written agreement between the hospital and the nonprovider entity to the effect that the hospital bears substantially all the training costs in the outside setting. However, section 1886(h)(4)(E) of the Act specifies that only time spent in activities relating to patient care may be counted toward the hospital's FTE count. In the proposed rule, we solicited comments on methods under which intermediaries can ensure that the portions of residency training programs that are spent in settings that are not a part of a hospital are spent in activities related to patient care. We specifically asked that suggestions address the data that hospitals would need to maintain to substantiate the nature of assignments to settings that are not a part of a hospital.

4. Determining the Number of FTE Residents

We proposed that the number of FTE residents for direct graduate medical education payment purposes would be determined by applying a weighting factor to each FTE resident, as explained below.

a. *Initial residency period and weighting factor.* Subject to special rules concerning certain foreign medical graduates, in general, the weighting factor that would apply to each resident in an initial residency period would be 1.0. Under section 1886(h)(5)(F) of the Act, an initial residency period means the period of board eligibility plus one year, not to exceed a total of five years.

Section 1886(h)(5)(G) of the Act defines the term "period of board eligibility" as it applies to a resident to mean the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training. The statute specifically requires that the 1985–1986 Directory of Residency Training Programs published by the American Medical Association (AMA) be used in determining the period of board eligibility. This directory indicates that most specialty boards no longer use the term "board eligible." However, as discussed in the proposed rule we believe that it is clear from the language of the statute that, for the purpose of determining initial residency periods, it is the intent of Congress that we use the minimum number of years of training required to qualify for a specialty board's certifying examination plus 1 year.

We also stated in the proposed rule that we believe that the definition of resident in section 1886(h)(5)(H) of the Act is intended to include residents in approved programs in osteopathy, dentistry, and podiatry as well as to residents who have a doctor of medicine (MD) degree. This intent is demonstrated by section 1886(h)(5)(D) of the Act which defines foreign medical graduates as those who have not graduated from a school of medicine, osteopathy, dentistry, or podiatry that is recognized by Medicare. There would be no need for such a definition unless residents in those disciplines were included in the definition of a resident. The Directory of Residency Training Programs (the Directory) can be used as a source document only for determining the lengths of initial residency periods for the types of medical programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). Therefore, for approved programs in osteopathy, dentistry, and podiatry, we contacted the appropriate accrediting organizations for these specialties and based our determinations of initial residency periods on the information they furnished to us. Whenever these accrediting bodies establish standards for new types of specialty programs, we have encouraged them to notify HCFA so that this information can be disseminated to our fiscal intermediaries.

Our proposed determination of initial residency periods for medical residency programs was based on the sections of the Directory entitled, "Essentials of Accredited Residencies" and "Requirements for Certification." The initial residency period includes years in a qualifying prior program. The 4 years of full funding for the internal medicine subspecialties includes the 3 years of a prerequisite general internal medicine program plus 1 additional year. The second year of a subspecialty training program receives a reduced weighting factor since it is in excess of the initial board eligibility plus 1 year criterion.

Although the Directory lists the minimum number of years for surgical residencies as 5 or more, we proposed to attach a weight of 1.0 to a surgical resident for 5 years, but not for an additional year, because section 1886(h)(5)(F) of the Act specifies 5 years as the maximum period we can count a resident as 1.0 FTE. Similarly, the Directory lists the minimum number of years for a residency in family practice as 3. Thus, we proposed that a family practice resident who specializes further in an approved program would be counted fully for the fourth year of GME training and partially for a fifth or subsequent year. In both situations residents would be counted partially after their initial residency periods (that is, .75 from July 1, 1986 through June 30, 1987 and .5 thereafter).

In addition, we proposed that a resident who has used up the time allotted to an initial residency period before July 1, 1986 and then participates in either the same or a different program would be counted only partially thereafter. As proposed, this would also apply to the situation in which a resident spends some time in one residency program and decides to change specialties before completing that program.

As was discussed in the proposed rule, some of the programs are subspecialty programs of other programs. For example, cardiology is a subspecialty of internal medicine. Section 1886(h)(5)(F) of the Act states that the initial residency period must be determined at the time the resident enters the residency training program. All of the subspecialties of internal medicine require that the subspecialty training be preceded by completion of an accredited program in internal medicine. Thus, the internal medicine residency program controls the length of the initial residency period. That is, the initial residency period would consist of a 3-year program in internal medicine plus 1 additional year of an appropriate subspecialty program.

Similarly, only one year of an accredited allergy and immunology residency would be included in an initial residency period since this program requires a 3-year residency in internal medicine as a prerequisite. As soon as a physician enters a basic internal medicine program, whether immediately after medical school or after a transitional year (see discussion below), the 3-year duration of the internal medicine program governs the length of time the resident is counted as 1.0 FTE. In this case, the initial residency period would be 3 years for

the internal medicine program plus 1 year (either a transitional year or a year of a subspecialty program, but not both).

Section 1886(h)(5)(F)(ii) of the Act provides for an exemption (up to 2 years) from the initial residency period limitation for individuals enrolled in a "* * * geriatric residency or fellowship program which meets the criteria as the Secretary may establish * * *." Currently, there is no private sector program of accreditation or approval for graduate programs of physician training in geriatric medicine. Accordingly, we were unable to obtain extensive information on geriatric programs prior to publishing the proposed rule. Therefore, we solicited comments on our proposed approach to implementing this provision of the law.

We proposed that geriatric fellowship programs, which an individual enters upon completion of a basic specialty program, should be the focus of the geriatric exception to initial residency periods established by section 1886(h)(5)(F) of the Act. It is our understanding that these fellowship programs are normally of 1 to 2 years' duration, and they are undertaken by residents upon completion of approved programs in internal medicine, family practice, or other basic specialty programs. Thus, if a resident completes a 3-year family practice program and enters a 2-year geriatric fellowship program, the latter would not be counted against the individual's initial residency period of 4 years. In fact, that individual could still have 1 additional year in another type of approved program upon completion of the geriatric fellowship program in which to be fully counted. Thus, that individual's initial residency period would be computed as follows: 3 years in a family practice residency program plus 2 years in a geriatric fellowship (not counted) plus 1 year in another unspecified approved program. In this way, the individual would be fully counted for 6 years of actual training even though his or her initial residency period consists of only 4 years.

It was our understanding that the ACGME will soon be establishing the criteria under which fellowships programs will be accredited as geriatric training programs for residents who have completed specialty programs in internal medicine or family practice. We proposed to use ACGME's criteria for purposes of determining what constitutes an approved geriatric fellowship program for these specialties. We also proposed that once the ACGME accredits a program in one of these specialties, HCFA will treat that program as an approved residency program for the purpose of including the participants of the program in the direct graduate medical education FTE count. We would treat the program as approved retroactively to the later of—

- The date the program was established; or
- The cost reporting period beginning on or after July 1, 1985.

We proposed to recognize these programs retroactively to the effective date of section 1886(h) of the Act (that is, cost reporting periods beginning on or after July 1, 1985) since Congress expressly provided for a geriatric exception in section 1886(h) of the Act. We also proposed to consider expanding the exception to geriatric fellowship programs in other specialties when the appropriate national organization establishes criteria for approving these programs.

In the last few years, ACGME has begun to accredit transitional year programs. The Directory indicates that these programs are provided for medical school graduates who—

- Have chosen a career specialty that requires as a prerequisite an entry year of fundamental clinical education;
- Desire a broader base of clinical experience than is initially provided by their chosen specialty; or
- Plan to enter active duty in the military.

These programs are apparently different from other ACGME accredited programs in that there is no board certification and, for initial residency period purposes, they must be considered in conjunction with other types of programs as set forth below. For these programs, there is no transitional year initial residency period limitation.

Several types of specialties, for example, anesthesiology, require a "clinical base year" or other type of fundamental training as an integral part of the accredited training program. In these cases, the transitional year program is counted as part of the medical specialty program for the purpose of determining the initial residency period and does not count as the additional year beyond initial board eligibility. For example, in anesthesiology, the one "clinical base year" is added to the 3 years of training in clinical anesthesia to comprise a 4-year training program. The additional year allowed by section 1886(h)(5)(F) of the Act would then be added to total a 5-year initial residency period (1+3+1=5).

In the case of a medical school graduate desiring a broader base of clinical experience, the transitional year is an additional year of training undertaken by a resident beyond the requirements for certification in a specialty. In these cases, we proposed that participation in the transitional year program would count as the additional year beyond the minimum number of years of training that is required for board certification. (Transitional year+number of years of training required for board certification=initial residency period, provided that the total does not exceed five years.)

In the case of the medical graduate planning to enter active duty in the military, there is a single year of broad-based clinical training in an ACGME accredited program before the resident enters active duty in the military. If the resident in this type of program is in his or her first residency program after graduation from medical school or has not exceeded the limits of an initial residency period in another specialty, we proposed that the resident be counted as 1.0 FTE for that one year. If the resident subsequently leaves the military and enters a residency program, the transitional year would be counted towards that resident's initial residency period at that time. However, any training in a residency program operated by the military that may be counted towards board certification would also count towards the initial residency period.

As stated in the proposed rule, we are interpreting the statutory use of the term "medical" in section 9202 of Public Law 99-272 to include osteopathic, dental, and podiatric residents. Section 1886(h)(5)(A) of the Act defines approved residency programs as those programs that count toward certification in a specialty or subspecialty.

It is our understanding that in most osteopathic graduate medical education programs, the first year of training is a rotating internship that is required prior to acceptance in a residency program. Specialized residency training does not begin until the second year of postgraduate training, which is counted as the first year of residency training in the osteopathic profession. Therefore, we proposed to treat the first year of osteopathic graduate medical education in the same fashion as the transitional year programs in medical programs. That is, since the rotating internship is required for further training in all programs, it counts as the first year of an initial residency period. Thus, we proposed that the first year would not be counted as the additional year beyond board eligibility as specified in the 1985-1986 Yearbook and Directory

of Osteopathic Physicians. For example, the Directory of Osteopathic Physicians specifies a 3-year residency for osteopaths entering internal medicine. We proposed to count such a resident for 5 years, the 1 year rotating internship plus 3 years, plus 1 additional year if that resident enters another year of approved training. In no case would any resident be counted as 1.0 FTE beyond 5 years.

Approximately one-half of all dental residents are in 1-year or 2-year general practice residencies. The information we have received from the American Dental Association indicates that general practice is neither a recognized dental specialty nor required or counted towards meeting the board eligibility requirement for dental specialties. Therefore, a strict application of the definition of an "approved medical residency training program" as set forth in section 1886(h)(5)(A) of the Act would preclude our recognizing these programs as approved programs under section 1886(h) of the Act. However, since we could find no evidence in the conference report that accompanied section 9202 of Public Law 99-272 that Congress intended a reduction in the types of programs Medicare supports, we proposed to continue to recognize dental general practice programs as approved programs under the authority of section 1861(b)(6) of the Act. However, the payment methodology to be used would be that proposed for implementation of section 1886(h) of the Act.

We proposed to treat dental general practice programs in the same way that we would treat transition year medical residency programs. A resident in a 1-year or 2-year general practice program would be counted as a resident in an approved program for the purpose of this section. However, if an individual enters a specialty program at a later date, the year or years of general practice residency would be counted toward the initial residency period for the specialty training. In the case of 2-year approved general practice residency programs, both years would count toward completion of the initial residency period for the specialty involved.

b. *Resident not in an initial residency period.* As required by section 1886(h)(4)(C)(iii) and (iv) of the Act, we proposed that the weighting factor for residents who are not in a period of initial residency (limited to 5 years) would be 1.00 prior to July 1, 1986, .75 during any portion of a hospital's cost reporting period occurring from July 1, 1986 through June 30, 1987, and thereafter would be .50.

5. Special Rule for Foreign Medical Graduates

a. *Definition of a foreign medical graduate.* We proposed that, as specified in section 1886(h)(5)(D) of the Act, the term foreign medical graduate (FMG) means an individual who is not a graduate of one of the following:

- A medical school accredited by the Liaison Committee on Medical Education of the American Medical Association which accredits medical schools in the United States and Canada (or approved by the committee as meeting the standards necessary for accreditation).
- An osteopathy school accredited (or approved as meeting the standards necessary for such accreditation) by the American Osteopathic Association.
- A dental or podiatry school that is accredited by an organization (or meets the standards for accreditation) recognized by the Secretary.

b. *Requirement for application of 1.0 weighting factor.* We proposed that, as specified in section 1886(h)(4)(D)(i) of the Act, effective July 1, 1986, a resident who is an FMG and who otherwise qualifies by being in an initial residency period would be considered to have a weighting factor of 1.0 only if the individual—

- Has passed Day 1 and Day 2 of the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS); or
- Has received certification from, or has passed an examination of, the Educational Commission for Foreign Medical Graduates (ECFMG) before July 1, 1986.

c. *Transition period rule.* We proposed that during a transition period from July 1, 1986 through June 30, 1987, the otherwise applicable weight for an FMG, who was a resident before, on, and after July 1, 1986 but who has not passed FMGEMS or met the ECFMG requirements would be multiplied by .5. Thus, any such resident who is no longer in an initial residency period would be counted as .375 FTE (.5×.75=.375). Any FMG whose residency begins on or after July 1, 1986, and who, by the date the residency begins, has not passed FMGEMS or received certification from or passed an examination of ECFMG, would not be counted at all.

d. *Counting FMGs who pass FMGEMS.* As was discussed in the proposed rule, once an FMG passes FMGEMS, the FMG is counted on the same basis as any other resident in an approved program. Thus, the FMG is counted as 1.0 if the FMG is in an initial residency period. For the period July 1, 1986 through June 30, 1987, an FMG who is not in an initial residency period would be counted as .75 and as .5 for the period beginning on July 1, 1987. The counting of FMGs is complicated by the fact that the time spent in an approved residency program counts toward the completion of an initial residency period regardless of whether the FMG who has not passed FMGEMS is partially counted or not counted at all. The definition of an initial residency period in section 1886(h)(5)(F) of the Act does not require that training be subsidized by Medicare in order for the training to be counted towards the completion of an initial residency period. Thus, any training that can be counted toward certification in a specialty, including any training outside the United States that has been deemed acceptable, is counted in the determination of the initial residency period.

6. Medicare Patient Load

Section 1886(h)(3)(C) of the Act defines "Medicare patient load" during a cost reporting period as "* * * the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A." This definition provides the basis for determining Medicare's share of GME costs that would be paid to a hospital or health care complex using the proposed payment methodology. We proposed that the calculation be made by dividing total part A inpatient days by total inpatient days (that is, Medicare and non-Medicare inpatient days) to determine the Medicare patient load. In the case of a health care complex, we proposed that the Medicare patient load for the hospital part of the complex be used as the Medicare payment share for the complex as a whole.

As proposed, the inpatient days would include inpatient days of the hospital that are payable under part A, which include special care units of the hospital along with its subproviders, including distinct part psychiatric, rehabilitation, and alcohol/drug units that are excluded from the prospective payment system. (We noted that alcohol/drug units were excluded from the prospective payment system for cost reporting periods beginning before October 1, 1987.) As is the case with other apportionment issues, hospital inpatient days of Medicare beneficiaries whose hospital stays are paid by risk-basis health maintenance organizations are recorded as non-Medicare days. Inpatient days applicable to hospital-based skilled nursing facilities and intermediate care facilities would not be

counted for the purpose of determining the Medicare patient load.

7. Apportionment Between Part A and Part B

Although section 1886(h)(1) of the Act provides for the "allocation" of Medicare payment between Part A and Part B, we interpreted this to mean that Medicare's liability for direct GME payment must be apportioned between the respective trust funds from which payments are made. We proposed that payment under Part A and payment under Part B be based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part for the individual provider as determined through normal Medicare cost finding rules.

8. Identifying Approved Teaching Programs

In addition to the changes required by section 1886(h) of the Act, we proposed to clarify what constitutes an approved program for the purpose of payment for direct GME costs. Program experience indicates that in the past there has been a problem in identifying approved teaching programs for certain medical subspecialties. These programs are sometimes called "fellowship" programs.

In some areas of medical specialty, subspecialty training programs have traditionally been accredited independently of general programs in the specialty. Examples of this are thoracic and neurological surgery programs that are accredited independently of general surgery programs. In other specialties, however, individual subspecialty programs were not accredited although they were given in conjunction with an accredited general specialty program. The most notable example of this situation is in the specialty of internal medicine. A resident completed a three-year program in general internal medicine and entered a fellowship program (for example, cardiology, nephrology, or oncology) for which the resident received a certificate of special competence by the appropriate board. Prior to 1986, these subspecialty programs were not individually accredited, and we have received several inquiries as to whether these programs should be treated as approved programs.

Historically, section 1861(b)(6) of the Act has provided the statutory basis for determining approval of GME programs. It cites approving bodies for graduate programs in medicine, osteopathy, dentistry, and podiatry The approving body for GME programs in medicine is currently the ACGME. (Section 1861(b)(6) of the Act cites the Council on Medical Education of the American Medical Association. This association has been replaced in this function by the ACGME. Section 1873 of the Act permits the recognition of successor organizations at the discretion of the Secretary.)

The Medicare program has generally treated fellowship programs as if they were accredited and paid for the services of residents in these programs as residents in approved programs. We argued in the proposed rule that it was not the intent of Congress, in adding section 1886(h)(5)(A) to the Act, to change that practice. The law and conference report do not indicate that section 1886(h)(5)(A) of the Act was intended to change the types of residency programs that Medicare supports except to expand the coverage to programs in geriatric medicine.

Section 1886(h)(5)(A) of the Act sets forth a new definition of an approved medical residency program that largely resolves any question about the status of these fellowship programs in past years. It defines an approved medical residency program as "a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty * * *." Thus, for the purpose of determining direct GME costs, Congress has shifted the emphasis from the accreditation of the program to the acceptability of the training for the purpose of attaining certification in a specialty or subspecialty. Further, the internal medicine subspecialty programs are now individually accredited by the ACGME.

However, section 1886(h)(5)(A) of the Act did not change the existing reference in section 1861(b)(6) of the Act with respect to approved programs. Therefore, we were faced with the rather complicated situation of having two statutory definitions of an approved residency program for cost reporting periods beginning on or after July 1, 1985. We proposed to resolve this matter by defining an approved program as a residency program in medicine, osteopathy, dentistry, or podiatry that is approved by one of the national accrediting bodies set forth in section 1861(b)(6) of the Act or that may be counted toward certification in a medical specialty or subspecialty cited in the 1985–1986 Directory of Residency Training Programs. Furthermore, any fellowship program that meets the requirements of an approved program in geriatric medicine as defined by the Secretary will also be included in this definition.

In the case of residents or fellows in programs that meet none of these criteria, we proposed that Medicare would pay its share of the costs of residents not in approved programs as described in § 405.523 of our regulations regarding residents not in approved teaching programs. Under § 405.523, hospitals are paid under Part B for up to 80 percent of the reasonable costs of services (that is, salaries and salary-related fringe benefits) of interns and residents who are not in approved programs, after payment of the Part B deductible by the Medicare beneficiary. No other educational program costs (that is, faculty compensation costs and other direct and indirect program expenses) in connection with such residents are payable. The Medicare beneficiary incurs the expense of deductible and coinsurance amounts as determined on the basis of the hospital's charges under Part B of the Medicare program.

The costs relating to patient care services of licensed physicians who are classified as "fellows" but who are not in an identifiable formal program leading to certification as defined in section 1886(h)(5) of the Act but remain at a teaching hospital/medical school complex to enhance their expertise in a field of study are payable on a Part B reasonable charge basis as physicians' services.

9. Special Treatment for States Formerly Under a Waiver From Medicare's Hospital Reimbursement System

Section 9202(j) of Public Law 99–272 provides that, effective with cost reporting periods beginning on or after January 1, 1986, hospitals in a State whose waiver under section 1886(c) of the Act for the operation of a State reimbursement control system has been terminated are permitted to change the order in which they allocate administrative and general costs to the order specified in the Medicare cost report. The only three States that were reimbursed under a waiver that has been terminated are Massachusetts, New Jersey, and New York. Hospitals in Massachusetts and New York were paid under a reimbursement system approved under section 402 of the Social Security Amendments of 1967 (Pub. L. 90–248) or section 222(a) of the Social Security Amendments of 1972 (Pub. L. 92–603).

Of these States, New York is the only State affected by this provision. Most hospitals in New York, including hospitals with direct medical education

cost centers, allocate administrative and general costs in a manner that differs from the recommended order prescribed in the Medicare cost report. Many of these hospitals use an order of allocation in which the administrative and general cost center follows, rather than precedes, the direct medical education cost centers. As a result of this methodology, none of the hospital's administrative and general costs were allocated to the direct medical education cost centers. This has had the effect of increasing the Medicare inpatient operating costs for teaching hospitals in New York and reducing the amount of medical education costs including the GME costs upon which the resident amounts are to be based. It was because of concerns about this matter that Congress enacted section 9202(j) of Public Law 99–272. Because New York never had a reimbursement control program approved under section 1886(c) of the Act, as specified in that section of Public Law 99–272, we provided for the same adjustment to be made in the September 3, 1986 final rule governing changes to the hospital prospective payment system (51 FR 31522) under the general exception and adjustment authority of section 1886(d)(5)(C)(iii) of the Act.

Under that authority, we provided for—

- An adjustment of Federal regional prospective payment system rates for the middle Atlantic census division (of which New York is a part) based on the assumption that all teaching hospitals in New York use the allocation order prescribed in the Medicare cost report; and
- An adjustment of the hospital-specific rate for hospitals that choose to follow the order of allocation prescribed by the Medicare cost report.

We proposed to use that same authority to provide an adjustment of direct GME costs for the cost reporting period beginning in FY 1984 for the purpose of determining per resident amounts.

In order to accommodate this adjustment, we proposed to allow hospitals in New York that have GME costs in the cost reporting period beginning in FY 1984 to change the method by which they allocate administrative and general costs to the method specified in the Medicare cost report for FY 1984 for the purpose of establishing per resident amounts. The intermediary would have to ensure that the shifted costs are properly allocated between cost of residency programs and costs of other medical education programs, since only the former go into the base used to determine the per resident amounts. These amounts should be updated as indicated for the cost reporting periods beginning on or after July 1, 1985, even though the per resident amounts will not serve as the bases of Medicare payment in these hospitals until January 1, 1986. Since the New York waiver ended for all hospitals effective December 31, 1985, the per resident amounts will be applied to cost reporting periods or portions of cost reporting periods effective January 1, 1986. As of that date, we proposed that direct GME costs of New York hospitals would be payable on the same basis that applies to hospitals in other States. This proposed provision would not affect payments for cost reporting periods or parts of cost reporting periods that fall before January 1, 1986. The New York teaching hospitals will have to continue to follow the specified allocation order to apportion costs between part A and part B thereafter.

10. Teaching Hospitals That Elect Cost Payments for Physicians' Direct Medical and Surgical Services Furnished to Medicare Beneficiaries

Section 1861(b)(7) of the Act provides that if all the physicians who furnish medical or surgical services to Medicare beneficiaries in the hospital agree not to bill charges for these services, a teaching hospital may elect to be paid on a reasonable cost basis for those services. This provision, as added by section 227 of the Social Security Amendments of 1972 (Pub. L. 92–603), was intended in part to simplify the administration of the program by eliminating the need for the hospital to document what portion of the physician's time is attributable to "medical and surgical services," and what portion constitutes "supervision of interns and residents." This documentation would otherwise be necessary in order to establish whether the "attending physician" criteria were met, which would allow the physicians to bill charges under Part B for their medical and surgical services. (See S. Rep. No. 1230, 92d Cong., 2d Sess. 198 (1972).)

We argued in the proposed rule that we do not believe that section 1861(b)(7) is inconsistent with section 1886(h) of the Act, which, as discussed above, provides that effective with cost reporting periods beginning on or after July 1, 1985, the direct costs of GME will be paid on the basis of per resident amounts, rather than reasonable cost. The per resident amount will be based on GME costs included in the hospital's intern and resident cost center in a specified base year.

For those hospitals that made the election under section 1861(b)(7) for cost reporting periods beginning prior to October 1, 1983, both physicians' medical and surgical services, and any supervision of interns and residents incident to furnishing the medical and surgical services in a hospital, were treated separately and paid through a special payment arrangement during the base year. Moreover, as explained above, there is no documentation that would provide the basis for distinguishing between the time spent on medical services as opposed to supervision. Accordingly, the supervision of interns and residents under these circumstances will not be reflected in the per resident amounts for payment of direct GME costs under section 1886(h) of the Act, but will be reimbursed separately, on a reasonable cost basis pursuant to the election provided by section 1861(b)(7) of the Act.

However, if a hospital made the section 1861(b)(7) election after the FY 1984 base year, the costs of supervising interns and residents would have been included in the intern and resident cost center, and therefore were included in the calculation of the per resident amount. Thus, the effect of the 1861(b)(7) election would be a duplicate payment for the supervisory services. Accordingly, for hospitals that elect the special payment method for cost reporting periods beginning on or after the FY 1984 base year, we proposed to adjust the per resident amounts for GME to reflect proportionately lower costs from those that are represented in the amounts determined for other teaching hospitals, in order to avoid duplicate payments.

11. End Stage Renal Disease (ESRD) Exception Criteria

Currently, payment for educational costs is included in the composite rate payment system for outpatient dialysis services. A hospital-based ESRD facility that incurs costs attributable to an approved residency or nursing education program may request an exception to its composite rate payment.

To qualify, a hospital-based ESRD facility must incur costs above its composite rate payment that are attributable to its educational program, as described in § 413.170(g)(3). Section 1881(b)(1) of the Act requires Medicare to pay for institutional dialysis services and supplies. Section 1881(b)(2)(B) of the Act determines how these outpatient dialysis services are paid. Neither of these sections requires Medicare to pay for medical educational costs under the

composite rate payment system. Under section 1886(h) of the Act, however, payment for GME costs in hospital-based ESRD facilities would be payable through per resident amounts. Therefore, we proposed that any costs attributable to approved residency, nursing, and paramedical training programs be excluded from the composite rate. Costs associated with approved residency programs would be payable through the per resident amounts. Costs incurred in connection with approved nursing and paramedical training programs would be reimbursable on a reasonable cost basis under the authority of § 413.85. Such treatment of these costs would eliminate the need for exception criteria for the cost of approved educational activities. This proposal would be applicable to cost reporting periods beginning on or after July 1, 1985, the effective date of section 1886(h) of the Act.

In conjunction with this proposal, in order to avoid duplicate payments that might result because of this statutory effective date, we proposed that it will be necessary to recover or offset any exception amounts already paid that are related to GME programs for cost reporting periods beginning on or after July 1, 1985, since these amounts would be payable through the per resident payment established by section 1886(h) of the Act. As stated in the proposed rule, HCFA would not approve any new composite rate educational exceptions once the proposed regulations are published in final in order to prevent overpayments from continuing.

III. Discussion of Public Comments

In response to the proposed rule, we received approximately 75 timely items of correspondence. Comments were received from hospitals and hospital associations, professional health-related organizations, intermediaries, and local governments. The specific comments and our responses to them are set forth below.

A. General Comments

Comment: Many commenters opposed the change from reasonable cost reimbursement to the per resident amount payments. One commenter pointed out that it adds another level of complexity to an already convoluted payment system, and that it does not result in a more equitable system of payment for direct GME costs.

Response: The modified payment system we are implementing was established by Congress in section 9202 of Public Law 99–272. In implementing this law, we have endeavored to produce as few disruptions as possible consistent with Congressional intent.

Comment: Several commenters cited the negative impact on their hospitals resulting from the retroactive application of section 1886(h) of the Act. One commenter pointed out that hospitals had made GME expenditures in good faith without knowing how the final rule would affect the hospitals' GME costs. Several commenters argued that HCFA should disregard the statutory effective date and that HCFA should implement section 1886(h) of the Act on a prospective basis only. One commenter gave an example of other statutory provisions in which effective dates were delayed administratively for various reasons.

Response: The statute requires that the new GME payment policy is to be effective for hospital cost reporting periods beginning on or after July 1, 1985. At the time of its enactment in April 1986, section 9202 of Public Law 99–272 was already a retroactive provision; that is, its effective date was cost reporting periods beginning on or after July 1, 1985. The fact that Congress passed the provision as a retroactive measure is a clear indication of Congressional intent that the statute be implemented retroactively effective with July 1, 1985. Moreover, we infer from the retroactive nature of the statutory provision that Congress viewed the methodology it was enacting as preferable to the methodology on direct medical education payments that the Department had adopted for cost reporting periods beginning on or after July 1, 1985 and intended that the new payment provision supersede the July 5, 1985 final rule. (On July 5, 1985, the Department published a final rule, effective July 1, 1985, in which allowable direct medical education costs were to have been limited to the lesser of the hospital's actual costs or the hospital's allowable costs incurred during a prior base period (51 FR 34790). Moreover, we believe that hospitals have had adequate notice that their Medicare payments for graduate medical education costs would be limited. Initially, hospitals should have anticipated a "freeze" in Medicare GME payments for cost reporting periods beginning on or after July 1, 1985 based on the publication of the July 5, 1985 final rule. As an interim step pending issuance of this final rule, we notified the public in the May 6, 1986 Federal Register that section 9202 of Public Law 99–272 specified a different approach to payment of direct medical education costs starting with cost reporting periods beginning on or after July 1, 1985.

Also, we understand that information about the enactment of section 9202 of Public Law 99–272 and its provisions was conveyed to teaching hospitals by their advocacy groups to encourage them to give due consideration to holding down their GME costs. It is obvious from the provisions of the legislation that Congress intended to place limits on Medicare participation in GME costs, and we believe that teaching hospitals should have been making decisions about their GME costs accordingly. Most of the provisions of the proposed rule (for example, the CPI–U update factor, the one percent update for the first year, and the weighting factors for residents) were specified in the law and should have been considered by teaching hospitals at least since the enactment of section 9202 of Public Law 99–272 on April 7, 1986.

Finally, we note that retroactive application of the new payment provisions will benefit some hospitals. Some hospitals will benefit from the new methodology for apportioning Medicare costs based on Medicare inpatient load and others will benefit from the removal of GME costs in making the lower-of cost-or-charges comparison. Hospitals that incur all or substantially all of the training costs for the time that residents spend in patient care activities outside the hospital setting will benefit from recognition of this time in the intern and resident FTE count effective July 1, 1987. Hospitals that operate a geriatric training program that receives accreditation from ACGME will benefit from treatment of the program as approved retroactively to the later of July 1, 1985 or the date the program was established. Failure to implement the provision retroactively would deny these hospitals the benefits to which they are entitled by statute. (Additional discussion of the circumstances that require retroactive application of this final rule is provided in section VI below.)

Comment: One commenter suggested that the revised payment method should apply only to hospitals subject to the prospective payment system and disagreed with our proposal to apply section 1886(h) of the Act to all hospitals and hospital-based providers and subproviders.

Response: We believe that it is clear from the language of section 1886(h) of the Act that it applies to all hospitals regardless of their status under the prospective payment system. Nowhere in that section is there any indication that Congress intended that it apply only to those hospitals paid under the provision of section 1886(d) of the Act. On the contrary, section 1886(h) of the Act refers only to "hospitals" or to "a hospital with an approved medical

residency training program," whereas the provisions in section 1886(d) of the Act concerning the prospective payment system usually refer instead to a "subsection (d) hospital" or to a "subsection (d) Puerto Rico hospital." (Those terms are defined in sections 1886(d)(1)(B) and 1886(d)(9)(A) of the Act.) Further, subsection (h) of section 1886 of the Act is the only subsection of that section that has a heading, "Payment for Direct Graduate Medical Education Costs." This unusual feature is a further indication that the provisions of subsection (h) are to be distinguished from the provisions on the prospective payment system (and related payment provisions) that are set forth in the preceding subsections of section 1886 of the Act. Thus, it seems clear that section 1886(h) of the Act was not intended to be limited to hospitals receiving payment under the prospective payment system. As discussed in the proposed rule at 53 FR 36590, we believe that it would be impractical not to apply the revised payment method to the entire healthcare complex. Any alternative would be too burdensome on all parties to administer.

Comment: One commenter stated that the change in payment method breaks a promise made by the Medicare program to pay for GME costs and will force hospitals to pass GME costs on to other payers.

Response: As noted above, these rules are necessary to implement legislation passed by Congress. We believe that when the three-fold Medicare response to GME programs is considered (that is, direct medical education payments, indirect medical education payments, and attending physician billing), there will continue to be a considerable commitment of Medicare funds to GME programs.

Comment: One commenter indicated that the retroactive application disrupts finality of payments under the prospective payment system.

Response: We do not believe this to be the case. We are instructing fiscal intermediaries to review GME base period amounts for the purpose of making the payments under the final rule as correct as possible for the future. Since payment for GME has been made as a pass-through cost rather than as part of the prospective payment rate, these payments (as with all other amounts paid on a reasonable cost basis) were always subject to reopening by intermediaries in appropriate cases within three years of settlement to correct erroneous payment. This would be the case, and has been taking place, independent of the enactment of section 1886(h) of the Act. As for the finality of payments made under the prospective payment system, the only payments that will be affected are hospital-specific payments during the transition period and this will be done at the request of a hospital for the benefit of the hospital for those cost reporting periods that are subject to reopening.

B. Determining Base-Period per Resident Amounts

Comment: Many commenters addressed the need to have consistency in the counting of resident FTE's between the base period and the payment periods and cited the individual circumstances of their hospitals with respect to funding sources of residency programs. A particular problem referred to was the treatment of residents who are paid by medical schools, faculty practice plans, and others rather than by hospitals that participate in Medicare. It was pointed out that teaching hospitals incur other costs such as teaching physicians' salaries and overhead costs in connection with these residents, and that it would be unfair not to count these residents for payment purposes.

One commenter suggested that residents who are paid a salary by nonhospital entities be counted as .25 FTE in recognition of these costs while another indicated that the GME costs not associated with residents' salaries were higher than the salary costs. A commenter from a major academic health center recommended that the one-day count of residents taken each September for indirect medical education payment purposes be weighted for individual residents as set forth in section 1886(h) of the Act and used for direct GME payment purposes also. The commenter pointed out that if that count was accurate enough for indirect medical education purposes, which involve much larger payments, it should suffice for direct GME payments as well.

Response: As we stated in the preamble to the proposed rule, the count of residents is the most complicated aspect of implementing section 1886(h) of the Act. Section 1886(h)(2)(A) of the Act states:

> The Secretary shall determine for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

As provided in section 1886(h)(3)(B) of the Act, the requirement for determining payments for cost reporting periods beginning on or after July 1, 1985 is that the updated per resident amount is multiplied by "* * * the weighted average number of full-time-equivalent residents * * * in the hospital's approved medical residency training programs in that period."

Nothing in section 1886(h) of the Act indicates that the bearing of certain types of costs in connection with particular residents is a factor in determining who should be counted. The law simply requires the Secretary to determine the average amount incurred to train residents during the specified base period and to make GME payments for the residents in the hospital's programs thereafter on that basis. There was no authorization to establish a two-tiered system to account both for residents for whom the hospital incurs full training costs and for residents for whom hospitals incur only supervisory and overhead costs because the residents' salaries are paid by another entity.

Not only does section 1886(h) of the Act not take into account the various types of financial arrangements that teaching hospitals have made for their GME programs, it also does not provide for reasonable modification of program arrangements after the base period. Thus, depending on the composition of GME costs during the base period, some teaching hospitals that later decide to change the financing of their GME programs could experience windfall profits, while others could experience a shortfall of the Medicare funding to which they had become accustomed. In short, the revised payment method is less flexible in responding to change than was reasonable cost reimbursement.

In responding to the various comments received, we would like to stress that we agree that there should be consistency between the residents counted in the base period and in the payment periods. The primary difference between the count of residents in the base period and in the payment years should be increases or reductions in the numbers of FTE residents in approved programs in the hospital during the cost reporting periods in question. The problem is how to count the residents in such a way that hospitals are treated as fairly as possible given the restrictions imposed by the revised payment method.

The revised payment method set forth in section 1886(h) of the Act seems to assume that GME programs remain relatively static except for upward and downward movements in the number of residents in a program. Carried further, the assumption seems to be that there is fairly constant rotation of residents to

other hospitals, and that the exchange of funds between program hospitals on a yearly basis is also fairly constant. While the apparent assumptions stated above would seem to argue for the use of a uniform one-day count of residents as has been the case with indirect medical education payments since cost reporting periods beginning on or after October 1, 1984, we have reservations about this approach. Specifically, we have concerns about proper application of the weighting factors across teaching hospitals. For residents beyond their initial residency period and for foreign medical graduates who have not passed FMGEMs, we have no assurance that the assignments of such residents on September 1 each year is actually reflective of the entire year. We believe that this is a much more important consideration with direct medical education payments than with indirect medical education payments since GME payments will be reduced for these categories of residents. The indirect medical education payments are made to teaching hospitals regardless of the weighting factors.

We proposed to use the number of residents shown on the Medicare cost report for the base period as the denominator in calculating a base-period per resident amount for each teaching hospital. Although one of the numbers entered on the cost report was for the purpose of calculating indirect medical education payments, the total number reported applied to the entire health care complex including hospital-based providers and subproviders even though the indirect medical education payment did not apply to these residents.

We concede that some commenters on the proposed rule were confused by our discussion of indirect medical education numbers in the preamble (see 53 FR 36593). We did not mean that the number used for indirect medical education payments was to be used as the denominator but the number entered on the cost report for the complex as a whole under indirect medical education counting procedures was to be used.

However, in response to the commenters' concern that the base-period count of residents be consistent with the method of counting residents for cost reporting periods beginning on or after July 1, 1985, we are modifying proposed § 413.86(e)(1) to specify that fiscal intermediaries will use a count of FTE residents for the GME base period that reflects the average number of FTE residents working in the health care complex during the GME base period. The residents' assignment schedules for the GME base period should already be included in the fiscal intermediary work papers since these assignment schedules were to be used to verify the "assigned time" or "FTE" statistics on Worksheet B–1 of the cost report which were used to allocate the GME cost to the various cost centers. If such documentation is not included in the fiscal intermediary work papers, the hospital will be required to present additional documentation to determine a base year count of residents consistent with the counting of residents after July 1, 1985. This information must be in a format that may be verified by the intermediary.

Several commenters were concerned that their base-period per resident amounts would be too low if the count entered on the FY 1984 cost report were used as the denominator since varying percentages of their residents received their salaries from other entities. The commenters argued that when these residents, for whom the hospital incurs certain nonsalary costs, are combined with residents for whom they incur full training costs, the hospital's base-period amount will be too low. We believe that this should not be a problem if the same financial arrangements apply in the payment years. The fact that one teaching hospital's per resident amount is significantly lower than another hospital's is immaterial if it accurately reflects base-year costs, unless the financial arrangements are changed.

However, we note that some of the comments have led us to believe that, in addition to Federally-employed residents (for example, residents in Veterans Administration or Department of Defense programs), a significant number of residents are paid a salary by non-Federal, nonprovider entities (for example, medical schools or philanthropic agencies). As noted by the commenters, although no hospital participating in Medicare incurs salary costs for these residents, hospitals do incur other substantial GME costs associated with these residents. Therefore, we are modifying our proposed rule to require Medicare hospitals to count residents who are working in their facility even if the residents' salaries are fully paid by other entities, either Federal or nonFederal. This revised counting policy will apply to both the GME base period and cost reporting periods subject to the new payment methodology.

Finally, we reject the comment of substituting a fractional FTE count for residents who are paid a salary by nonhospital entities in both the base period and the payment years, because the financing of GME programs varies so widely as to preclude arriving at an appropriate uniform figure. The following examples are provided to illustrate the counting of residents under the revised GME payment methodology:

EXAMPLE 1:

In its GME base period (cost reporting period beginning July 1, 1984), teaching hospital A had 502 residents filling 500 slots in its various GME programs (4 residents share 2 slots). Hospital A is a health care complex that also includes a skilled nursing facility (SNF), a comprehensive outpatient rehabilitation facility (CORF), and a home health agency (HHA). Teaching hospital A paid the salaries of 402 residents while the remaining 100 residents had their salaries paid by another entity. The assignment of the 502 residents was as follows:

Number of residents	Salary paid by	Where assigned (percent of time)
1. 198	Hospital A	Prospective payment unit of Hospital A—100%.
2. 4 (sharing 2 slots)	Hospital A	Prospective payment unit of Hospital A—50%.
3. 10	Hospital A	Prospective payment unit of Hospital A—50%; Excluded units of Hospital A—50%.
4. 10	Hospital A	Prospective payment unit of Hospital A—50%; Freestanding clinic—50%.
5. 180	Hospital A	Prospective payment unit of Hospital A—50%; On rotation at other hospitals—50%.
Total 402		
6. 80	Medical school	Prospective payment unit of Hospital A—75%; SNF, CORF, HHA of Hospital A—25%.
7. 20	Veterans' Administration	Prospective payment unit of Hospital A; 25%; On rotation at other hospitals—75%.
Total 100		

For the purpose of calculating Teaching Hospital A's base-period per resident amount, the total number of residents to be included in the denominator is 390, computed as follows: (Line 1)+(Line 2×0.5)+(Line 3)+(Line 4×0.5)+(Line 5×0.5)+(Line 6)+(Line 7×0.25)=198+2+10+5+90+80+5=390.

If we assume that the number of residents remains the same in all future years, and that all residents are within their initial residency periods, and that all foreign medical graduates have passed FMGEMS or its equivalent, then for the cost reporting period beginning July 1, 1986, Hospital A would count 390 residents for payment purposes under the new payment methodology. Effective July 1, 1987, Hospital A would count 395 residents since the hospital incurs substantially all of the costs for the 10 residents that spend 50 percent of their time in freestanding clinics. If Hospital A did not incur substantially all of the costs for the 10 residents, the hospital would continue to count 390 residents (and no payment would be made to the hospital for the time the residents spend in freestanding clinics).

Example 2

Hospital B does not have a GME program, however, at any given time, 20 residents from approved programs at other hospitals are on rotation at Hospital B. The other hospitals pay the salaries of all 20 residents. The other hospitals cannot count the residents for the portion of their time they spend at Hospital B. Hospital B compensates one hospital a fixed amount per month for each of 10 residents provided by the hospital. Hospital B is not required to provide any compensation for the other 10 residents. For the purpose of calculating Hospital B's base period per resident amount, the total number of residents to be included in the denominator is 20. (The costs are the costs incurred by Hospital B for the 20 residents; that is, the amounts paid to the other hospital and the nonsalary costs incurred by Hospital B.) If we assume that the number of residents remains the same over time, and that all residents count as 1.0 FTE in future periods, then for cost reporting periods subject to the new payment methodology, Hospital B would also count 20 residents for payment purposes.

Comment: Several commenters objected to the use of the indirect medical education count in calculating the base period per resident amounts, and suggested that residents assigned to excluded units such as psychiatric units be included in both the base year and payment year counts.

Response: As was discussed above, it has been our intention all along to count residents assigned to excluded units, hospital-based skilled nursing facilities, and other providers and subproviders of the health care complex. Proposed § 413.86(e)(1) did not specify that the indirect medical education count be used in the calculation. Rather, it specified that the number of residents reported on the cost report should be used. Residents assigned to excluded units are reported on the cost report. To clarify this point, we are adding an additional sentence to § 413.86(e)(1), in addition to the changes discussed above, to make it clear that all residents reported for all components of the complex (other than residents hired to replace anesthetists, as provided in § 413.85(d)(7)) would be counted in calculating base-period amounts. In addition, we are classifying in § 413.86(f) how residents, including those working part-time and on rotation, will be counted in the payment years.

Comment: Several commenters indicated that there were problems with using the indirect medical education count of residents in the base period since the count of residents assigned to the hospital as of the first working day in September is independent of the payment of salaries.

Response: We believe the commenters are confused about the method used in the base-period count of residents. The base period for determining per resident amounts under section 1886(h) of the Act is the cost reporting period beginning in FY 1984. At that time, the one-day September count was not the basis upon which the indirect medical education count was made. Rather, the indirect medical education count was based on the number of residents working at the hospital and employed by either this hospital or by an organization that has a longstanding medical relationship with the hospital and that is the sole employer of substantially all the residents furnishing services at the hospital.

However, as was discussed above, we are modifying § 413.86(e)(1), in response to commenters' concerns, to specify that fiscal intermediaries will use a count of FTE residents for the base period that reflects the average number of FTE residents working in the health care complex during the base period.

Comment: Several commenters pointed out that the 35-hour a week threshold was applied to the indirect medical education count on the cost report that will be used for the GME base-period calculation and could affect the base-period amount. It was suggested that hospitals should be allowed to adjust their base-period FTE counts to take this factor into account.

Response: As discussed above, we proposed to use the count of residents entered on the cost report under indirect medical education provision for all components of the complex because that number was available. However, based on comments received, we are modifying § 413.86(e)(1)(i) of the proposed rule to specify that fiscal intermediaries will use a count of FTE residents for the GME base period that reflects the average number of FTE residents working in the health care complex during the GME base period.

Comment: One commenter indicated that HCFA's concern about the correctness of GME base period costs is unfounded since there was extensive audit activity of these costs for both the prospective payment base period and the first cost reporting year of the prospective payment system.

Response: It may not be necessary to reaudit all teaching hospitals in setting the base-period rates. However, several situations have been brought to our attention in which physicians' costs incurred for activities unrelated to GME, malpractice costs, and medical library costs have been misclassified as GME costs or excessive administrative and general service costs were allocated to the GME cost center. Thus, we believe that there is a basis for reaudit activity where indicated.

Comment: Some commenters were concerned that some records necessary to support payments made in the base period may no longer be available, and that since most hospitals have already undergone audits, the commenters believe that they should be given the benefit of the doubt when supporting documentation is unavailable. The commenters also pointed out that, with respect to section 1886(h)(4)(E) of the Act, which permits the counting of the time residents spend in nonhospital settings for the teaching hospital that bears the training costs of the residents in the outside setting on or after July 1, 1987, some hospitals would be unable to document from their affiliation agreements which entity paid the residents' salaries.

Response: Obviously, all records used to support the reimbursement of costs are not of equal importance in determining the allowability and classification of costs. While it may be necessary at some point for HCFA to set a policy on this issue, we would find it hard to believe that teaching hospitals would not have some supporting documentation of costs incurred no more than 5 years ago. Furthermore, even if the information is no longer available at the hospital, the fiscal intermediary would have retained some of the documentation in its workpapers.

With respect to the provision effective July 1, 1987, the only requirement is for

documentation that the hospital pays for the training costs, specifically residents' salaries, in the outside setting. If hospitals cannot document that they incurred salary costs for certain residents in 1987, they should not receive GME payments for those individuals.

Comment: One commenter asked for clarification of why we would reopen cost reports that had been settled for more than 3 years if no adjustments to amounts paid in that year could be made.

Response: The commenter is referring to our proposed policy to allow hospitals who have had misclassified operating costs removed from their GME base period costs to request an upward adjustment to their hospital specific rate (HSR) during the prospective payment transition period reflecting these higher operating costs. If costs that were misclassified as GME in the GME base-period costs received similar treatment in the prospective payment base period, there would be a basis for an upward adjustment of the hospital's HSR. To make this adjustment, it is necessary to use the cost report from the prospective payment base period even though payments in that year might not be affected. The affected years would be those cost reporting periods subject to reopening in which the HSR was a factor in the hospital's payments under the usual provisions of § 405.1885 (that is, within 3 years of settlement).

Comment: Some commenters argued that hospitals that are excluded from the prospective payment system should be permitted to request to have their target amount recomputed to reflect misclassified costs in the same way prospective payment hospitals may request to have their HSRs recomputed.

Response: We agree with the commenters that this adjustment should be made. We are revising the proposed regulations to include this provision (see § 413.86(j)).

Comment: One commenter objected "* * * to legislation which, for the government's convenience, allows a modification to the hospital specific base rule for any errors found to be applied retroactively, while denying hospitals retroactive application to all other known errors (those supported by successful appeals)."

Response: There is nothing in section 1886(h) of the Act that addresses the recomputation of HSRs. However, we believed that the enactment of section 9202 of Public Law 99–272 was a special circumstance calling for special treatment of the costs involved. Under both situations in which we have proposed recomputation of HSRs, the recomputation works to the benefit of the hospitals involved.

Comment: One commenter questioned whether the proposed reopening of cost reports will allow areas other than GME to be reopened.

Response: As indicated in the proposed rule at 53 FR 36592, we are making a one-time adjustment solely for the purposes of correctly classifying GME costs. We do not intend that any other areas of the cost report be reopened.

Comment: Several comments oppose the review and potential reopening of cost reporting periods beginning in FY 1984 for the purpose of setting base-period per resident amounts. One commenter representing a group of physicians pointed out that Congress made the clear-cut decision that the figures for that year would serve as the base period and expressed concern that different standards would be applied on audit that were not applied originally.

Response: Section 1886(h)(2)(A) of the Act provides that the Secretary must determine, for the cost reporting period that began during FY 1984, the average amount recognized as reasonable. We would find it hard to believe that Congress intended that misclassified and nonallowable costs continue to be recognized through the GME payment indefinitely. The first cost reporting period under the prospective payment system will serve as the base period for the new GME payment policy. We believe that GME costs were not given sufficient scrutiny at the time because of the many changes that were taking place in Medicare generally. We would like to assure all interested parties that no new reimbursement principles will be applied during the reaudit. Rather, our intent is to ensure that the reimbursement principles in effect during the GME base period were correctly applied. Moreover, we are clarifying § 413.86(e)(1) to indicate that if a hospital's base-period cost report is no longer subject to reopening under § 405.1885, the intermediary may modify the hospital's GME base-period costs solely for purposes of computing the per resident amount.

Comment: One commenter requested clarification of whether the proposed rule permits recalculation of the prospective payment base-period rate and adjustments to reimbursement for all years since the beginning of the prospective payment system.

Response: Even if section 1886(h) of the Act had never been enacted, intermediaries would have had the authority to reopen cost reports within 3 years of settlement to correct erroneous direct medical education pass-through cost reimbursement amounts. What the proposed rule does is to allow hospitals to request to have their HSR adjusted upward whenever the retroactive disallowance of misclassified GME costs would result in no payment for what are otherwise allowable operating costs of the hospital, (that is, an overpayment that the Medicare program otherwise would have to recover). Adjustments to the HSR (and the target rate for hospitals excluded from the prospective payment system) will be made for cost reporting periods that are still subject to reopening (that is, within 3 years of settlement) under the usual provisions of § 405.1885.

Comment: One commenter pointed out that the proposed rule permits limited revision to the HSR, but there is no discussion of the effect on Federal rates.

Response: The Federal portion of the prospective payment rates in effect during the transition period will not be revised as part of this final rule. We believe it would be inappropriate to change all hospitals' prospective payments retroactively to take account of changes to a subset of teaching hospitals' costs. The prospective payment system, as legislated by Congress, was designed to set payments in advance, and payment rates were established based on the best data available at the time.

Comment: One commenter suggested that, during any reaudit activity, hospitals should be able to introduce additional GME costs not previously claimed, as well as misclassified costs, to augment base-period GME costs.

Response: We would seriously question the legitimacy of costs introduced 4 or 5 years after the base-period cost report was prepared by the hospital. However, if it can be demonstrated to the satisfaction of the fiscal intermediary that legitimate GME costs were inadvertently omitted from the base-period cost report, then these costs could be introduced during the reaudit activity. However, these costs would have to be supported by actual documentation developed during the GME base-period that was maintained in a format that can be audited. Costs other than GME costs could not be introduced if the cost report is not otherwise subject to being reopened.

Comment: One commenter pointed out that the GME base period costs include capital costs properly allocated to GME programs and raised a number of issues arising from the fact that capital payments related to GME will be limited by the CPI–U on the same basis as GME payments generally. It was noted that such a limit on capital payments related

to GME ultimately restricts growth and does not take into consideration future expansion and increases in debt.

Response: It is true that the revised GME payment method established by section 1886(h) of the Act locks into place a teaching hospital's cost circumstances as they existed during the base period with no provision for modifying per resident amounts to reflect changes in those circumstances. We infer from the lack of an exception for capital or any other category of costs related to GME programs that it was the intent of the Congress to do this. The practical result of this policy is to preclude additional payments for capital costs related to GME for cost reporting periods beginning on or after July 1, 1985, except to the extent such costs might be payable through per resident amounts.

Comment: Several commenters questioned the need for reaudit activity of GME base-period costs since there is no reason to believe that the results would be more consistent on reaudit than they were after the original audit.

Response: Periodically, findings have come to our attention that indicate that fiscal intermediaries were inconsistent in their application of GME policy under reasonable cost reimbursement. The enactment of section 1886(h) of the Act, with its potential to perpetuate misclassified and nonallowable costs through the per resident amounts, compels us to take actions to strive for consistent treatment of GME costs. Reaudit guidelines for the intermediaries have been prepared by HCFA. We believe that the reaudits will clear up these problems.

Comment: Some commenters expressed concern about treatment of GME costs of a related medical school. One commenter pointed out that, in some complexes, GME activities may take place in space assigned to the medical school, and that it would be unfair to impose a restriction on the location of allowable GME patient care activities in large academic health care centers for reimbursement purposes. Another commenter was concerned that medical schools often are adequately funded by grants from State and local governments, so it seems inappropriate for the medical school under such circumstances to also pass-through such costs to the hospital. In the opinion of the commenter, we should address whether there is a redistribution of GME costs when State appropriations or other funding sources are sufficient to cover the costs of operating the medical school.

Response: We agree that determination of allowable costs of related medical schools can be a complicated matter. We are guided by the general principle that, to be allowable at all, the costs must be related to patient care furnished in the hospital, and, to be allowable as a direct GME cost, the costs must be related to the GME program in the hospital. Certain identifiable activities conducted by the faculty of a related medical school, which are necessary for the clinical training function at the hospital, may represent allowable costs for Medicare program purposes. These activities include supervision of interns and residents in activities for which no Part B charge is made and the conducting of rounds and patient care conferences related to hospital patients. To reiterate, services that are both related to the care and treatment of the hospital's patients and furnished in support of the training of interns and residents meet the requirements for payment.

These items and services must be necessary and directly related to the provision of medical school faculty services in the hospital and may not be duplicative of items and services furnished by the hospital. For example, if the hospital is unable to provide office space or clerical support to the physicians supervising its interns and residents, a portion of those costs that are incurred by the university medical school may be allowable if it can be demonstrated to the satisfaction of the fiscal intermediary that such costs are directly related to the training program of the interns and residents working in the university hospital and are related to the care and treatment of the hospital's patients.

In the past, hospitals have alleged that the related organization principle set forth in § 413.17 requires Medicare to reimburse a hospital for a share of all costs of a medical complex or even of the entire university on the basis that the component entities were indistinguishable from the whole. Our policy concerning related organizations was established to avoid program recognition of costs of a provider for services furnished by a related organization in excess of the costs incurred by the related organization, and to avoid payment of artificially inflated costs that might be generated from less than arm's length bargaining. This policy was not intended to expand the range of items and services for which a provider could claim Medicare reimbursement, or to include items and services not specifically related to patient care.

With respect to the comment that we should address the issue of funding that covers the costs of operating the medical school, our policy prior to October 1, 1983 provided that restricted grants (those grants that were designated by the donor for paying certain specified provider costs) were deducted from the designated costs incurred by the provider. Unrestricted contributions, however, would not be deducted from such costs. Section 901 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499) added section 1134 of the Act. This provision affirmed the Secretary's authority not to offset donor-restricted grants and gifts that the Secretary finds, in the best interests of needed health care, should be encouraged. The policy that restricted grants could be offset against allowable costs incurred by providers was changed effective October 1, 1983 (as provided in the September 1, 1983 final rule (48 FR 39797)). Thereafter, any grant monies received by a provider could not be offset against the reimbursable amounts due the provider under Medicare.

Comment: One commenter suggested that a date should be set by which intermediaries must decide whether a cost report should be reopened based on findings made during reaudit activity so that hospitals will not be penalized due to the tardiness of their intermediaries' actions.

Response: We do not agree. As pointed out in the preamble to the proposed rule, budgetary restraints that have been placed on contractors make specific time schedules for this activity impractical. We will, however, begin this review and reaudit as soon as possible after publication of this final rule.

Comment: One commenter indicated that the 3-year restriction on reopening cost reports should not be waived for the reaudit activity and the consistency requirement of the regulations for direct medical education costs during the prospective payment system transition period should be applied in defining GME costs on a per resident basis.

Response: We would like to reiterate that payments will not be affected for cost reporting periods that have been settled for more than three years. Rather, we proposed that cost reports settled for more than 3 years could be re-examined for purposes of modifying the hospital's target amount or HSR in subsequent years still subject to reopening. With respect to the second part of the comment, the consistency clause in § 412.113(b) was never intended to recognize operating costs misclassified as GME costs. It was designed to prevent hospitals from

claiming amounts on a reasonable cost basis for the types of costs already included in its HSR. As part of the September 30, 1988 prospective payment system final rule, we removed the portion of § 412.113(b) dealing with the consistency rule for medical education costs. With the expiration of the transition period, the restrictions on the classification of medical education costs were no longer needed for cost reporting periods beginning on or after October 1, 1987. We removed this requirement so it would not be confusing in future cost reporting periods. However, we now believe that the requirement for consistent treatment of medical education costs during the transition period should remain in the regulations to enhance understanding of the treatment of misclassified costs for purposes of determining the GME per resident amount and adjusting the HSR. Therefore, we are making the changes as proposed to § 412.113 and retaining in § 412.113(b)(3) the consistency rule for medical education costs.

Comment: One commenter expressed concern with the proposal to review, and, in some cases, reaudit GME base period costs because of an "* * * arbitrary and capricious application of a 'suspicion' by fiscal intermediaries that such costs are high."

Response: The GME base period under section 1886(h) of the Act was also the first period under the prospective payment system, a period in which many changes were occurring in the Medicare program. The costs that were classified as costs of approved educational activities did not always receive the scrutiny they should have. Several instances of misclassified costs have come to our attention, and we believe that it is necessary to correct these errors before incorporating these FY 1984 costs into the per resident amounts that will not be revised again except by an update factor. Because of this, we believe that it is imperative that we do our best to ensure that these amounts are correct.

Comment: One commenter suggested that different per resident amounts be established for each type of specialty program to reflect the differing costs of the programs.

Response: The revised payment method established by section 1886(h) of the Act made no provision for such differentiation. Further, it would be extremely difficult to calculate such amounts from Medicare cost reports since the costs of all GME programs are aggregated within one cost center on the cost report.

Comment: One commenter requested clarification as to how overhead would be apportioned between GME programs and nursing and allied health training programs.

Response: All overhead associated with GME programs will be payable only through the per resident amount, regardless of the actual costs incurred, based on the overhead costs during the base period. Overhead costs incurred in connection with approved nursing and allied health training programs will continue to be reimbursed on a reasonable cost basis under existing cost report procedures.

Comment: We were asked to elaborate on the appeals process with respect to the computation of the per resident amount. One commenter suggested that a hospital be permitted to make an initial appeal to the fiscal intermediary within 180 days of receipt of the notice of its per resident amount. Then, if still dissatisfied, the hospital could appeal to the Provider Reimbursement Review Board (PRRB) within 180 days of the revised notice.

Response: Once the intermediary computes a per resident amount that the intermediary believes is correct, the intermediary will notify the hospital that this is HCFA's final determination. Upon receipt of this notification, the hospital has 180 days in which to appeal the intermediary's determination. Although the hospital must appeal to the PRRB, it can continue to negotiate with the intermediary to resolve any dispute with respect to the intermediary's determination. The hospital has no appeal rights after 180 days have elapsed since its receipt of the original notice or any revised notice of its per resident amount. (A revised notice would be issued in response to further negotiation between the hospital and the intermediary, as a result of the issuance of a revised Notice of Program Reimbursement for the GME base period at a later date, or in response to a PRRB or court determination.) It should be noted that the per resident amount determination process is separate from the settlement of GME payments made on or after July 1, 1985. For settlement of GME payments made on or after July 1, 1985, the hospital can still appeal the count of residents for the cost reporting year in question or the application of the update factor in the settlement of GME payments. We are modifying § 413.86(e)(1) to further clarify these points.

C. Updating Per Resident Amount in Subsequent Years

Comment: One commenter suggested that the CPI–U, which we proposed to use to update per resident amounts for cost reporting years beginning on or after July 1, 1986, will always be less than actual inflation and salary increases. The commenter proposed that the CPI–U should be replaced by a factor representing the average increase in GME costs among teaching hospitals.

Response: Section 1886(h)(2)(d) of the Act specifically requires that per resident amounts be updated yearly based on the estimated percentage change in the Consumer Price Index. Section 1886(h)(5)(B) of the Act defines the Consumer Price Index as the Consumer Price Index for All Urban Consumers (United States city average (CPI–U)). Therefore, we believe we are barred by the statute from setting any update factor other than the CPI–U.

Comment: One commenter indicated that the precedent set in the past 5 years by the update factors established for the prospective payment system leads the commenter to anticipate that the update factors for GME costs will not be reflective of costs.

Response: As noted above, the update factor (that is, the CPI–U) to be applied to GME payments is established by section 1886(h) of the Act. The factor itself is determined by another component of the Federal government (that is, the Secretary of Labor.) We note that the update factors for the prospective payment system are not based on the CPI–U. Therefore, we do not believe that comparisons between the two update factors can be made.

Comment: One commenter opposed our policy to not use an update factor for base cost reporting periods beginning from July 1 through September 30, 1984, alleged that the one percent update factor applicable for the first cost reporting period beginning on or after July 1, 1985 was arbitrary and without substantiated support, objected to the application of the revised payment methodology to outpatient departments, and suggested that the GME base period be established for cost reporting periods beginning in FY 1990 rather than FY 1984. Another commenter suggested that the one percent update for the first payment year be replaced by the CPI–U, as is the case with subsequent years.

Response: All of the provisions to which the commenter is objecting are based on the provisions of section 1886(h) of the Act. The point of having an update factor for the base period is to account for the inflation in an intervening period between the base period and the first payment period. Hospitals with cost reporting periods beginning from July 1 through September 30, 1984 do not have such an intervening period thus eliminating the need for an update factor. While the commenters

may be dissatisfied with the one percent update factor, the figure was established by Congress, as was the effective date of the legislation and its application to hospital outpatient settings.

Comment: One commenter suggested that HCFA should quantify the update factors to be used for cost reporting periods beginning on or after July 1, 1986 and establish a publication date of the update factors to be applied to future periods.

Response: We agree. We plan to publish actual and projected update factors in an annual notice that will be published in the **Federal Register** before July 1 of every year in order that hospitals will be able to plan accordingly. The update factors for the cost reporting periods beginning on or after July 1, 1986 are listed in Table 1 of the appendix to this final rule.

Comment: Several commenters suggested that use of the CPI–U update factor be replaced by indexes more closely related to the inflation experienced by teaching hospitals such as the hospital market basket index or the CPI–U for the geographic area in which the hospital is located.

Response: As explained in detail above, section 1886(h)(2) and (h)(5)(B) of the Act require the use of the increase in the CPI for all teaching hospitals. We do not believe that we have the authority to interpret those provisions of the law in any other manner.

D. Counting Residents in Years Subject to the Revised GME Policy

Comment: One commenter pointed out that fully counting all residents in the base period while applying the initial residency period weighting factors in subsequent years will create an automatic decrease in payments.

Response: We believe that this was clearly the intent of Congress as the language of sections 1886(h)(2)(A) and (h)(4)(C) of the Act leaves us no discretion in implementing these provisions.

Comment: One commenter indicated that the application to past periods of weighting factors for graduates of foreign medical-schools and residents no longer in initial residency periods would be inequitable, and the factors should be applied on a prospective basis only.

Response: As has been pointed out previously, section 9202 of Public Law 99–272 was a retroactive provision when it was enacted, and we believe that Congress intended that the factors be applied as indicated in section 1886(h) of the Act to achieve the intended savings from the revised payment methodology.

Comment: One commenter requested that we change our proposal to count a resident for only the hospital in which he or she spent the majority of the month to a prorated count between the hospitals.

Response: We agree. We had originally believed that a monthly count would be significantly less burdensome than a daily or hourly count, or a count on any other basis. However, in order to attribute the count of a resident to the hospital in which the resident spent the majority of the month, sufficient documentation would be required so that prorating the resident across hospitals would probably not require that much additional time and effort. Therefore, we will instruct hospitals and fiscal intermediaries to apportion the time spent by each resident among the hospitals based on the number of days (or portions of days if necessary) worked at each facility. It will be necessary for the hospital to maintain documentation acceptable to the fiscal intermediary to verify that no resident is counted as more than one FTE during the graduate medical education academic year, regardless of the number of hospitals in which he or she is providing services or the total number of hours of service provided.

Comment: Several commenters suggested that the problem of counting rotating residents would be best resolved by making all payments to the hospital that is the primary sponsor of the program. One commenter pointed out that, while some hospitals would not be paid for costs they incur for teaching and supervision of the residents, they would be adequately "repaid" by the services provided by residents to the patients at that hospital.

Response: Section 1886(h)(2) of the Act requires that "The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount * * *." We do not believe that we have the authority to restrict the number of hospitals for which an approved FTE resident amount will be computed.

Comment: In the preamble to the proposed rule (53 FR 36596), HCFA requested comments on methods by which intermediaries can ensure that the time spent by residents who are assigned to work in nonhospital settings and who will be counted under section 1886(h)(4)(E) of the Act is spent in patient care activities. Some commenters argued that it was not necessary to establish criteria for verification that the time residents spend in nonhospital settings is spent in patient care activities. It was pointed out that this would establish a separate standard for those residents that would not apply to residents in hospital settings and, in any case, the overwhelming majority of time spent in these settings is related to patient care. One commenter suggested that the time be documented by residents' logs of their activities. Another commenter stated that any verification effort should require minimum documentation. It was suggested that it was enough for the hospital to certify that all requirements of the residency program are being satisfied by the training in nonhospital settings.

Response: We have reviewed the comments, some of which recommended extensive recordkeeping that we believe is unnecessary, and have decided that it is not necessary to account for every hour the resident spends in nonhospital settings. Essentially, section 1886(h)(4)(E) of the Act simply ensures that the FTE amount attributable to an individual resident is not reduced below 1.0 simply because he or she is assigned to a freestanding clinic for a portion of his or her residency program. Therefore, we are not changing our original proposal that there be a written agreement between the hospital and the nonhospital entity that the resident will spend substantially all of his or her time in patient care activities, and that the resident's compensation for the time spent in the outside entity is paid by the hospital. We would also like to clarify that, where a hospital has such an agreement with a nonhospital entity, appropriate reductions are to be made to the September 1 indirect medical education count of interns and residents in approved programs to reflect the fact that some residents are assigned to settings outside the hospital. (See § 412.118(h).)

Comment: One commenter requested clarification as to the treatment of short cost reporting periods in the GME base period and in periods beginning on or after July 1, 1985. The commenter felt that counting a partial month as a full month in the base period would understate the base period amounts while the opposite would be true in the payment years.

Response: We agree. Therefore, we are modifying § 413.86(e)(4)(ii) to provide that daily averages are multiplied by the number of days in a year to achieve a more equitable base period average per resident amount. We are not modifying § 413.86(e)(4)(iii) since that subclause does not discuss the adjustment in terms of monthly amounts, and it would only be reasonable to prorate a month as

applicable for payment purposes for cost reporting periods beginning on or after July 1, 1985.

Comment: One commenter expressed concern about the inability to update the list of approved residencies and their initial residency periods from the 1985 edition of the Directory of Residency Training Programs to the 1989 edition of that book.

Response: Section 1886(h)(5)(G)(ii) of the Act indicates that we must use periods necessary to satisfy the requirements for board eligibility as specified in the 1985–1986 Directory of Residency Training Programs (the Directory) published by the ACGME. Section 1886(h)(5)(G)(iii) of the Act indicates that initial residency periods may be changed beginning July 1, 1989 if the ACGME increases or decreases the minimum number of years for board eligibility in its revised Directory. We intend to adopt a similar approach to publications concerning approved programs in osteopathy, dentistry, and podiatry. However, the provision applies only to the number of years of training necessary to satisfy the requirements of a specialty and does not affect our ability to recognize additional types of programs. In this regard, we applied initial residency periods to subspecialty programs in internal medicine that were not listed in the 1985–1986 edition of the ACGME Directory.

Comment: A law firm representing the Society of Critical Care Medicine commented that fellowship programs in Critical Care Medicine should be added to the listing of approved GME programs in Internal Medicine, Anesthesiology, Surgery, and Pediatrics. A letter from the Accreditation Council for Graduate Medical Education was submitted indicating that residency programs in Surgical Critical Care Medicine, Anesthesiology Critical Care Medicine, and Critical Care Medicine (Internal Medicine) will be approved during 1989, and that the approved programs would be listed in the Directory of Graduate Medical Education Programs published in March 1990.

Response: We are adding the three types of programs that have been approved to our listings, effective July 1, 1989. The complete list of approved GME programs and the corresponding initial residency periods is set forth in Table 2b of the appendix to this final rule. We shall await additional information on the status of Pediatric Critical Care Medicine programs. If such programs are approved at some later date, we will make the appropriate changes in a notice we plan to publish in the **Federal Register** before July 1 of every year listing the limits on initial residency periods for the various specialty and subspecialty programs for the academic year beginning on July 1.

Comment: The American Association of Dental School notified us that effective July 1989, oral and maxillofacial surgery residency programs will require an additional year of training. Similarly, the American College of General Practitioners in Osteopathic Medicine and Surgery notified us that on July 1, 1989, the length of training in osteopathic general practice program will be increased by one year.

Response: As discussed in the previous response, we plan to publish a notice in the **Federal Register** before July 1 of every year listing the limits on initial residency periods for the various specialty and subspecialty programs for the academic year beginning on July 1. We are making the changes referred to in the comment in Table 2b of the appendix to this final rule which will serve as the notice applicable to July 1, 1989.

Comment: One commenter pointed out that some residency programs require less than the 5-year limit for completion while others require more than 5 years. The commenter suggested that some latitude be given in recognizing these variations.

Response: We do not believe that the provisions of section 1886(h) of the Act permit these variations. While the conference report that accompanied Pub. L. 99–272 (H.R. Rep. No. 453, 99th Cong., 1st Sess. 481 (1985)) is not explicit on why Congress set this limit, we must infer that Congress intended a reduced Medicare participation in longer programs.

Comment: Several commenters requested clarification of how the initial residency period limit applies when a resident changes from one specialty program to another. One commenter suggested that the first portion of GME training not be counted toward completion of an initial residency period while another inquired whether training in both programs will be counted. It was pointed out that, under the proposed rule, the number of years of prior training becomes a factor in the selection process because of the payment implications.

Response: An individual resident would have only one initial residency period. Section 1886(h)(5)(F) of the Act requires that the initial residency period be determined at the time the resident enters the residency program. We believe it was the intent of Congress that any time spent in an approved GME program would be counted toward the overall limit, and that Congress provided an additional year beyond that necessary to be eligible for board certification to address situations such as a change in specialty programs. It would not be necessary for a resident to complete a program to have the years spent in that program counted. Thus, if a resident transferred from a 3-year program after the second year to a 5-year program, the initial residency period of the 3-year program would set the limit. As a practical matter, this would have the effect of counting the resident as .5 rather than 1.0 for only 1 year more than if the 5-year program's limit was used.

If it were the intent of Congress that a new initial residency period begin whenever a resident changes programs or hospitals, there would have been no need to use the adjective "initial", and the overall limit would be meaningless. We would add that, if eligibility for Medicare payments becomes a criterion for the selection of residents by officials of residency programs, it is a further indication that Medicare has become the financier of GME programs to an inordinate degree.

Comment: Representatives of the specialities of Internal Medicine and Family Practice requested clarification of the status of individuals who are spending a fourth year in a program such as General Internal Medicine and Family Practice that usually is a 3-year program. It was pointed out that some programs have added a fourth year for a variety of reasons. In other programs, individuals who have completed their requirements for board certification spend a fourth year as a chief resident and are technically no longer in a program leading to certification in a specialty or subspecialty.

Response: If it is clear that these individuals are actually in formally organized approved programs, we believe that they should be counted as residents in approved programs even if the individual has completed the requirements for board certification. The situation is not unlike those we discussed in the proposed rule concerning Transitional Year programs and General Dentistry programs, neither of which, in itself, lead to certification in a specialty or subspecialty. We do not believe that Congress enacted section 1886(h) of the Act to reduce the types of programs recognized by Medicare. Thus, if the ACGME and other accrediting bodies recognize such individuals as residents in the General Internal Medicine or Family Practice program, we would count them for purposes of direct GME payments at .5 or 1.0 FTE depending on whether they are still in

their initial residency period. We would differentiate these individuals from those who have completed their residency but remain for an additional period of time within the academic settings to continue their training outside the context of a formally organized approved program. Individuals in the latter group should be paid as physicians.

Comment: One commenter cited situations in which residents who plan research or academic careers take time off from the normal course of their residency programs to pursue a year or two of research and laboratory work. Since residents in these situations would not be counted for purposes of direct GME payments, the commenter believed that it should be clarified that such years would not count against their initial residency periods.

Response: We can envision situations in which GME training that may not be counted for direct GME payment purposes could, nevertheless, be counted against the initial residency period such as in the case of an FMG who has not passed the FMGEMS. However, in the situation presented, it appears that such residents would not be in an approved GME program and, thus, should not be counted for either direct, or indirect, GME payment purposes.

Comment: One commenter pointed out the different results that can occur when a medical school graduate enters a transition year program before selecting a specialty program and when another graduate enters a general internal medicine program and uses the latter program as an internship year prior to selecting another specialty program. In the former case, the resident's initial residency period is determined by the specialty program selected after the transition year, while in the latter case, the resident's initial residency period is limited to the 4-year period assigned to internal medicine. The commenter believes that in the latter case, the graduate has made himself or herself a less attractive candidate for the specialty program they ultimately chose.

Response: This is probably an unintended result of the legislation. It would be unfortunate if someone's career plans were negatively affected in this way. However, section 1886(h)(5)(F) of the Act requires that the initial residency periods shall be determined at the time the resident enters the training program. We believe that this precludes starting a new initial residency period every time a resident changes a program.

Comment: One commenter indicated that the concept of "initial residency period" as proposed penalizes residents (and their hospitals) who change from one specialty program to another. These changes may take place for various reasons such as lack of adequate training or inappropriate career counselling.

Response: We believe that, by the use of the word "initial," Congress intended the provision to be implemented as we proposed. Otherwise, there would be no need to use that term. We concede that there could be individual residents who are negatively affected by this provision, but we believe that we have no discretion in the application of the overall five-year limit.

Comment: Several commenters pointed out that counting residents by their monthly assignments will be particularly difficult for past cost reporting periods to which section 1886(h) of the Act would apply. One suggested that the indirect medical education count be used for the past periods and that the monthly count should be used prospectively.

Response: We believe that hospitals or GME program directors should have this information for the cost reporting periods in question. We also believe that it would not be appropriate to use the indirect count for those periods since it would not be possible to apply the weighting factors without specific information on the residents involved.

Comment: One commenter believes that we acted prematurely in publishing the proposal on counting graduates of foreign medical schools (FMGs) prior to Congressional action on the recommendations of the Council on Graduate Medical Education on FMGs. The commenter went on to indicate that it was unfair to require FMGs to pass FMGEMS while not requiring graduates of American medical schools to pass the National Board of Medical Examiners' examination.

Response: The proposed rule essentially restates the statutory provisions on counting procedures for FMGs (section 1886(h)(4) (C) and (D) of the Act), and we cannot ignore a provision of law enacted by Congress on the basis that the law might be changed in the future. Further, the statute gives HCFA no discretion with respect to the implementation of this provision. We would like to point out that once an individual FMG passes FMGEMS, he or she is treated by Medicare on the same basis as any other resident in an approved GME program.

Comment: In commenting on the proposed rule, a representative of the Public Health Service pointed out that, beginning in September 1989, the Education Commission for Foreign Medical Graduates (ECFMG) will be offering the National Board of Medical Examiners' Part I and Part II examination to graduates of foreign medical schools (FMGs) as an alternative to the FMGEMS.

Response: Section 1886(h)(4)(D) of the Act provides that, generally, to be counted for payment purposes beginning July 1, 1986, an FMG must have passed FMGEMS or previously received certification from, or has previously passed the examination at, the ECFMG. Section 1886(h)(5)(E) of the Act provides that, "the term, 'FMGEMS' examination, means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose." It does not specify a particular sponsoring organization for the examination. Since the ECFMG has recognized an alternate examination and since the Secretary is willing to accept this change, we believe that he is directly authorized to do so under section 1886(h)(5)(E) of the Act. Accordingly, we are adding a new subparagraph (h)(5) to § 413.86 to state that beginning September 1, 1989, passage of both parts of that examination may be substituted for passage of FMGEMS.

Comment: One commenter asked why it was necessary for us to know the school the resident graduated from and the date of the graduation.

Response: Section 1886(h)(4)(D) of the Act requires that we identify residents who are graduates of foreign medical schools and to ascertain whether these residents qualify to be counted for payment purposes. Intermediaries need to know the date of graduation from medical school in order to ensure that all GME training time has been counted for purpose of determining the limit of an initial residency period.

Comment: One commenter suggested that the exception to the 5-year overall limit on initial residency periods should be applied to other specialties in which there are shortages of physicians such as family practice, anesthesiology, and physical medicine.

Response: We believe that the language of section 1886(h)(5)(F)(ii) of the Act makes it clear that Congress intended to exempt only geriatric programs from the ceiling on initial residency periods.

Comment: One commenter suggested that the regulations clearly state that resident time studies, for purposes of allocation on Worksheet B–1, are no longer required.

Response: We do not believe that it is necessary to include this type of detail in the regulations; it would more

properly be handled through operating instructions. To clarify the point, however, since reimbursement is not made on a reasonable cost basis, resident time studies would not be required for payment purposes. However, any time residents are assigned outside the hospital should be documented as set forth in § 413.86(f).

Comment: One commenter suggested that HCFA should take into consideration changes that have taken place in GME training in ambulatory settings and apply the provision to count time spent in nonhospital training sites retroactively to the GME base period costs.

Response: The provision on counting time spent in outpatient settings in section 1886(h)(4)(E) of the Act that was added by section 9314 of Public Law 99–509 has an effective date of July 1, 1987, and a change in that date would compromise some of the savings contemplated by the enactment of section 1886(h) of the Act. Further, HCFA changed its policy in the 1970's to allow the services of licensed residents in nonprovider settings to be covered as physicians' services payable on reasonable charge basis even though the services were furnished within the scope of an approved GME program. These billings would not be allowed where the provisions of section 1886(h)(4)(E) of the Act are applied.

E. Determining Medicare Patient Load

Comment: One commenter opposed the substitution of "Medicare patient load" (based on inpatient days only) for the traditional approach of determining Medicare's share of GME costs and payments. The commenter believed that this approach is inconsistent with other Medicare policies and regulations that encourage more procedures to be performed in outpatient settings thereby reducing the Part A inpatient load.

Response: Section 1886(h)(3)(A) of the Act specifies that the Medicare patient load is the basis to be used in determining Medicare's share of the GME payments. Section 1886(h)(3)(C) defines Medicare patient load as "the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payments may be made under Part A." While this provision gives the Secretary some flexibility in deciding which inpatient days are to be counted, it is clear that Congress intended that inpatient days are to be used for this purpose. We recognize that this provision will affect some hospitals negatively while others will receive a higher payment than would otherwise be the case.

Comment: Some commenters indicated that it was not clear whether the inpatient days of a subprovider, such as psychiatric or rehabilitation units that are excluded from the prospective payment system, are counted in calculating the Medicare patient load in a health care complex. One commenter pointed out that it was inconsistent to count inpatient days in excluded units while not counting inpatient days of hospital-based skilled nursing facilities. The commenter indicated that excluded units are likely to have lower Medicare utilization and not to be part of a hospital's GME program. Another commenter expressed concern that our definition of "Medicare patient load" could have a negative impact on a health care complex with a large skilled nursing facility.

Response: We believe that the preamble discussion on this point at 53 FR 36600 was clearer than the regulation text and we are modifying the definition of "Medicare patient load" in § 413.86(b)(2). The Medicare inpatient days and total inpatient days of all components of a health care complex that are classified as part of the "hospital" are added together to determine the Medicare patient load for the complex. Inpatient days of a hospital-based skilled nursing facility would not be counted in calculating the Medicare patient load since the facility is not classified as part of the "hospital". We believe that this approach is consistent with the special method of determining Medicare utilization established by Congress in section 1886(h)(3)(C) of the Act. It treats similarly situated hospitals consistently, regardless of their connections (if any) with skilled nursing facilities.

Comment: Some commenters suggested that section 1886(h) of the Act should apply only to hospitals paid under the prospective payment system. One commenter believed that the policy on determining "Medicare patient load" that is based on all inpatient hospital days of a health care complex is inappropriate because residents are never assigned to the excluded psychiatric units in some hospitals and counting the inpatient days of the unit would skew the GME payments.

Response: There is nothing in the language of section 1886(h) of the Act or its accompanying conference report that indicates that it should apply only to prospective payment hospitals. We believe that the Congress intended the revised payment method to apply to all hospitals and hospital-based providers.

Comment: Several commenters requested clarification as to whether nursery room days (or newborn days) are counted when the ratio of inpatient bed days payable under Part A to total inpatient bed days is calculated for the purpose of determining the Medicare patient load.

Response: It has been the standard practice to exclude nursery room days in all Medicare computations that involve inpatient days since the Medicare program does not incur any liabilities for nursery room costs. We believe that such days should also be excluded in the determination of Medicare patient load for the purposes of this provision. Therefore, we are modifying the definition of "Medicare patient load" in § 413.86(b) to clarify this point. However, consistent with this treatment of nursery room days, no GME costs that are allocated to the nursery room cost center in the GME base period will be included in the GME base-period per resident amount.

Comment: One commenter opposed the application of section 1886(h) of the Act to the outpatient dialysis facilities of hospitals. It was pointed out that determining utilization under the Medicare patient load does not take into consideration that the patient group affected in these outpatient departments is virtually 100 percent Medicare.

Response: We believe that the substitution of GME payments based on per-resident amounts under section 1886(h) of the Act for reasonable cost reimbursement in all components of hospitals is required by the statute. An integral part of the revised payment methodology is the use of inpatient statistics alone to determine Medicare utilization for GME payments. While the commenter has raised a valid point, we do not believe that section 1886(h) of the Act gives us the authority to continue reimbursement for GME costs on a reasonable cost basis in these facilities. On the contrary, section 1886(h)(4)(E) of the Act specifically provides that all the time spent by a resident under an approved program must be counted without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.

Comment: Some commenters asked for clarification of whether the part of the GME payment apportioned for Part B will be paid at 100 percent or 80 percent.

Response: 100 percent of the Part B GME amount will be added to Medicare Part B allowable costs after excluding actual GME costs and after subtracting

the 20 percent coinsurance amount charged to the beneficiary under the regular provisions applicable to hospital outpatient services.

Comment: Two commenters requested clarification as to the treatment of Part B inpatient days in calculating the Medicare patient load for payment purposes.

Response: The commenters have raised a point that was not discussed in the proposed rule and is a further example of the widespread effects of section 1886(h) of the Act on many areas of Medicare payments to hospitals. In the early years of Medicare, it was decided administratively that once a Medicare beneficiary's Part A benefits expire, it was appropriate to count any remaining days of hospitalization as Part B inpatient days. In this way, a per diem payment could be developed for these beneficiaries to compensate teaching hospitals for GME costs under Part B even though no reimbursement was available under Part A.

The GME payment made under section 1886(h) of the Act is a substitute for all reasonable cost reimbursement in hospitals and health care complexes for the costs of approved GME programs under both Part A and Part B. Therefore, in settling cost reports for periods beginning on or after July 1, 1985, no reasonable cost payments will be made for GME costs attributable to Part B inpatient days. Also, these days would not be counted in calculating the Medicare patient load since section 1886(h)(3)(C) of the Act specifies that only inpatient days payable under Part A would be counted in making this calculation. We note that with the implementation of the Medicare Catastrophic Coverage Act (Pub. L. 100–360) on January 1, 1989, Part B inpatient days will no longer occur as a result of the expiration of Part A benefits. However, we do recognize there may be relatively few Medicare inpatients who do not have Part A coverage but do have Part B coverage.

F. Apportionment Between Part A and Part B

Comment: Some commenters asked whether GME payments apportioned to Part B in accordance with proposed § 413.86(d)(3) are to be subjected to the lesser-of-costs-or-charges provision set forth in § 413.13 on the same basis as hospital outpatient costs.

Response: The payment methodology established by section 1886(h) of the Act is a self-contained payment provision without reference to the usual Medicare payment provisions. It is a substitution for reasonable cost reimbursement of GME costs that had previously been made under section 1861(v) of the Act. Payments are to be made under the provisions of section 1886(h)(3) of the Act, which does not contain a lesser-of-costs-or-charges provision. Accordingly, we believe that it would be inappropriate to apply the lesser-of-costs-or-charges provision to payments that are not determined on a reasonable cost basis since the outpatient component of the GME payments made under section 1886(h) of the Act is to be made to the hospital regardless of the costs actually incurred by the hospital. Therefore, effective with cost reporting periods beginning on or after July 1, 1985, the lesser-of costs-or charges comparison is made with no GME costs (or section 1886(h) payments) included in the cost element of the comparison. (The Medicare cost report will be modified to exclude actual GME cost in the comparison.)

The effect of this policy position will vary depending on the circumstances of individual hospitals, and it will be necessary to adjust retroactively the settlements that have been made with regard to some teaching hospitals effective back to cost reporting periods beginning on or after July 1, 1985. Hospitals will be advantaged in situations in which a hospital's allowable Part B costs were higher than its charges in past periods resulting in a reduction in Medicare reasonable cost reimbursement to the level Medicare charges. These hospitals will receive GME payments for some or all of their costs that were not reimbursable under the lesser-of-costs-or-charges provision. On the other hand, the hospitals that were exempted from lesser-of-costs-or-charges provision by section 2308(b)(1) of the Deficit Reduction Act of 1984 (Pub. L. 98–369) because their charges were considered "nominal" by virtue of being 60 percent or less of the reasonable costs of services or items represented by the charges could be disadvantaged by this policy. These hospitals could lose their exemption from the lesser-of-costs-or-charges provision if, in comparing costs to charges for purposes of the nominality test, GME costs are not included in reasonable costs. To avoid having unreimbursed costs, these hospitals would need to reduce their charges in order to retain their nominal charge status or alternatively, forego their exemption and raise their charges.

We do not believe it would be appropriate to implement a policy that would require these hospitals to either alter their charge structures or face reductions in reasonable cost payments. We recognize that hospitals take their full costs into account in establishing their charge structure and believe it is appropriate that they continue to do so without facing reduction in Medicare payments. Therefore, we are providing that, solely for the purpose of applying the nominality test, reasonable costs will include GME payments rather than GME costs. The use of GME payments, which are subject to a special apportionment methodology, offers the simplicity of avoiding the need to determine actual GME costs. In fact, the use of GME payments, if greater than actual GME costs, will provide an advantage to the hospital by causing the nominality test to be met more easily. However, if the hospital believes that its actual costs are greater than the GME payments, it may use its actual GME costs in applying the nominality test if it can demonstrate to the intermediary that its actual reasonable costs are greater. If the intermediary can be assured that the hospital's actual reasonable GME costs applicable to Medicare patients covered under Part B are greater, such costs will be used in lieu of the Medicare Part B GME payments in the nominality test.

Comment: One commenter argued that the proposed method of apportioning GME payments between Part A and Part B would be arbitrary and incorrect and should only be used if the hospital cannot provide specified documentation of GME costs. It was also pointed out that the hospital cannot recover the applicable Part B deductible and coinsurance amounts under this methodology.

Response: First, we note that the revised payment methodology results in GME payments that are not based on a hospital's actual costs incurred for GME programs. Under this provision, a teaching hospital could receive more or less than it actually incurs for the programs. Thus, we believe that it cannot be maintained that Congress intended that the GME payments reflect actual current GME costs. Second, the apportionment process does not affect the total direct GME payments to be made. Rather, it is used to determine the respective trust funds from which payments are to made. Finally, with regard to the point on Medicare beneficiary copayments, these payments are made by beneficiaries based on a hospital's Part B charges, not costs. The proposed apportionment method would have no effect on this aspect of the Medicare program.

G. Other Comments

Comment: Many commenters suggested that an exceptions process be established to take into consideration

changes that take place in a hospital's GME program after the base period. Among the many examples given of changes that might take place were modifications of salary arrangements regarding the residents, the need to pay higher salaries to fill certain residency slots, and new arrangements involving space costs allocated to GME activities.

Response: We believe that Congress intended to establish a payment method that has a historical basis in the GME costs of individual hospitals during the base period, but which is not based on actual costs incurred for GME programs in any year thereafter. Thus, section 1886(h) of the Act does not provide for an exceptions procedure that would raise or lower per resident amounts based on some new circumstance of the program. The only exception provided by Congress applied to hospitals that did not have a GME program during the base period or that were not participating in Medicare during that period. We can only infer that had Congress intended that a more general exceptions process exist, it would have provided for this in provisions of the law or in the conference report. Further, it could be argued that if it were intended that the per resident amounts reflect actual costs, there would have been little point in changing the payment method already in effect in 1986. Congress could have simply retained reasonable cost reimbursement with some limiting factor on the rate-of-increase in the costs of these programs.

However, Congress provided instead for a hospital-specific payment that may be characterized as similar to the hospital-specific rate used in the prospective payment system. As such, the payment method is neutral with regards to hospital-specific costs. For example, a hospital could change its arrangements with its teaching physicians in such a way that the physicians are no longer receiving a salary for their services associated with the GME programs. These hospitals could conceivably make a profit on their GME programs since they would continue to receive per resident amounts based on costs they no longer incur. We believe that it was the intent of Congress not to take these sorts of program changes into account but, rather, to leave it to the hospitals to adjust for such changes in view of the amount of payment they are receiving.

Comment: One commenter pointed out that the provisions of the proposed § 405.521(d)(3) allow for an adjustment to be made for situations in which a teaching hospital may elect to be reimbursed on a reasonable cost basis for direct medical and surgical services furnished to individual patients, in lieu of reasonable charge payments that might otherwise be payable for such services, for the first time in a cost reporting period beginning on or after the effective date of section 1886(h) of the Act. The proposed rule accommodated this election (which is made under the authority of section 1861(b)(7) of the Act) by providing for the removal of physician compensation costs related to the supervision of interns and residents in approved programs in the care of individual patients from the GME base-period costs to prevent duplicate payments. The commenter suggested that a similar accommodation should be provided for the opposite situation in which a hospital withdraws the election in a cost reporting period beginning on or after the effective date of section 1886(h) of the Act. This would involve augmenting the GME base-period costs by costs incurred for the supervision of interns and residents in the care of individual patients.

Response: Section 1886(h) of the Act does not address the special payment provision of section 1861(b)(7) of the Act, that is, the cost election for reimbursement of physicians' direct medical and surgical services in teaching hospitals. In our proposed § 405.521(d)(3), we provided for the special circumstance of teaching hospitals making the cost election both because it was still an effective payment provision and because we believed that it was possible to make the necessary adjustment to the GME base-period costs. However, we do not believe that it would be possible to make the necessary adjustment to the GME base period in the situation of a hospital that withdraws the cost election after the effective date of section 1886(h) of the Act.

The term "direct medical and surgical services" was established in § 405.465 (which implements part of section 1861(b)(7) of the Act) and encompasses the following types of activities engaged in by physicians in teaching hospitals:

- Services in which teaching physicians exercise an overall supervisory role over the cases in which residents treat patients.
- Services in which teaching physicians are more actively involved in the care furnished to individual patients by residents to the extent that a fee would be payable in the absence of the cost election (that is, there is an attending physician relationship).
- Services personally furnished by the physicians without involvement of residents.

One of the major features of section 1861(b)(7) of the Act, originally enacted as part of section 227 of Public Law 92-603, was the administrative simplicity that resulted from relieving teaching hospitals, intermediaries, and carriers from having to distinguish which of the three circumstances applied in individual cases. Costs representing all three types of cases would be included without separate identity in the amounts paid under the cost election while only the costs that fall into the first category would be appropriately included in the GME cost category. Since the different types of costs are not separately identified, we do not believe it would be possible to adjust GME base-period costs if the cost election were withdrawn.

One of the reasons a teaching hospital would want to drop the cost election for physicians' direct medical and surgical services would be to institute fee-for-service billing for physician services furnished to Medicare patients. This would apply both to services personally performed by the physician and those which he or she furnishes within the context of an attending physician relationship. The only classification of costs for which a teaching hospital would not be paid would be the less intensive role of supervising residents in the care of individual patients where no attending physician relationship is established. Other physician compensation costs associated with the GME program would not have been reimbursable through the cost election mechanism but as direct GME costs during the GME base period. The teaching hospital could address any shortfall from not recognizing the supervisory services of teaching physicians in the care of individual patients by upgrading the physicians' involvement to that of an attending physician role. The supervisory role of the physician would then be recognized through reasonable charge billing under Medicare Part B, and we believe that this would have been the whole purpose of changing to a fee-for-service situation. Hence, we believe that, in the situation described by the commenter, there is an available mechanism (that is, Part B reasonable charge billing) to address the change.

Comment: One commenter indicated that the payment policy in the proposed rule seems to favor GME programs that are fairly stable and fails to take into account rapid changes that are taking place in GME training.

Response: We have inferred from the revised payment method established by section 1886(h) of the Act that, for Medicare payment purposes, Congress intended to freeze direct GME financial arrangements as they existed during the base period subject to an update factor for inflation and recognition of changes in the number of residents in approved programs. It has the effect of tying Medicare payments to the financial arrangements that existed in the base year, regardless of any future changes in such arrangements. However, the subsequent enactment of section 1886(h)(4)(E) of the Act by section 9314 of Public Law 99–509 does provide for at least one exception in that training in settings other than Medicare providers would be recognized for payment purposes.

Comment: One commenter suggested that hospitals in New York State be allowed to use their first year under the prospective payment system (that is, cost reporting periods beginning on or after January 1, 1986) as the GME base period rather than the generally applicable FY 1984 cost reporting period.

Response: The statute requires that per resident amounts be based on hospital cost reporting periods that began during FY 1984. We have no authority to revise that base period. We note that the revised GME payment methodology applies to both hospitals subject to and excluded from the prospective payment system. Therefore, there would seem to be no reason for using a different base period for a hospital simply because the State chose to apply for a waiver from the prospective payment system.

Comment: One commenter believed that the proposed policy concerning the determination of per resident amounts for hospitals that did not participate or have an approved medical residency training program during base period was unclear as to whether it applied to any new programs in a hospital with existing programs, or only to a hospital that starts its first GME program after the base period. This policy was proposed in § 413.86(e)(5) and is now located in § 413.86(e)(4).

Response: This policy applies only to hospitals that either were not participating in Medicare during the base period or that had no approved GME program during the base period. The provisions of section 1886(h) of the Act provides for additional new programs in teaching hospitals with existing programs by recognizing changes in the number of residents in approved programs.

Comment: One commenter representing a hospital that began its first GME program after its cost reporting period beginning in FY 1984 believes that the costs incurred for the first program year are not representative of the actual yearly costs of its program since it became fully operational. The commenter pointed out that the hospital incurred program costs prior to the entrance of residents into the program, that residents' salaries would be understated in the initial years because of the absence of senior residents from the program, that faculty physicians and plant facilities came into use at various times, and that start-up costs were inherently different from ongoing program costs. The commenter suggested that per resident amounts of other teaching hospitals be used as a floor rather than a ceiling in calculating a base period amount for new programs. Another commenter recommended that new programs be given a three-year exemption from the revised GME payment methodology, and be paid during those years on the basis of reasonable costs. The third year of operation would then become the base year for determining the per resident amount for all future periods.

Response: We believe that the commenters have raised some very valid points about new GME programs in that all elements of the program do not fall into place at the same time. Further, we believe that the applicable provision of section 1886(h) of the Act did not envision a situation in which a hospital's GME program began on July 1 of a given year, while the hospital's cost reporting period began on some other date, such as October 1 or January 1. In such a situation, the first year of the program would not be reflective of the costs of the program since residents might be on duty and receiving a salary during as few as one or two months of the cost reporting period. Further, a strict application of the law would preclude any recognition of start-up costs incurred in a cost reporting period before the arrival of residents since the counting of residents in the program is the payment vehicle for GME costs. On the other hand, ongoing GME programs often undergo changes with additions and reductions of staff and facilities. There will be many situations in which a hospital's GME payments under the provisions of section 1886(h) of the Act may fall short of a hospital's actual GME costs during a particular cost reporting period. We believe that it is implicit in the revised payment method that Congress intended that no special adjustments be made if this should happen.

However, we believe that instances in which a hospital begins a GME program for the first time after the GME base period will be rare, and we wish to reach a reasonable accommodation as to the per resident amounts payable to these hospitals. Accordingly, we are modifying § 413.86(e)(4) (proposed § 413.86(c)(5)) to provide that the base period for determining per resident amounts in hospitals that begin a GME program after the base period will be the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period. Any GME costs incurred for the prior cost reporting period will be made on a reasonable cost basis under section 1861(v) of the Act as was the case for cost reporting periods beginning prior to July 1, 1985. We agree that basing payments on an unrepresentative base period could have an adverse effect on a hospital; however, we are also bound by the statutory language of section 1886(h)(2)(E) of the Act, which deals with hospitals that start a GME program only after 1984. We believe that the modifications we are making in § 413.86(e)(4) of the proposed rule represent a reasonable compromise between these two conflicting objectives but are also consistent with the statutory language.

IV. Summary of Changes from the Proposed Rule

For the convenience of the reader, we are briefly summarizing the major changes we have made in this document.

- We have revised § 413.13 to specify the treatment of GME costs and payments under the lesser of costs-or-charges provision.
- We have modified the definition of "Medicare patient load" in § 413.86(b)(2) to be the total number of Medicare hospital inpatient days during the cost reporting period divided by total hospital inpatient days. In calculating inpatient hospital days, nursery days are excluded and only hospital distinct part days are included.
- We have revised § 413.86(e)(1) to specify that the intermediary will use a count of FTE residents for the GME base period that is reflective of the average number of FTE residents working in the health care complex during the GME base period.
- We have also revised § 413.86(e)(1) to clarify that all residents reported for all providers of the health care complex will be counted in calculating base-period amounts and that a hospital may appeal the intermediary's determination of the hospital's base-period average per

resident amount within 180 days from the date of the intermediary's notice.

- We have also revised § 413.86(e)(1) to clarify that costs allocated to the nursery and to research and other nonreimbursable cost centers are excluded in determining GME base period costs.
- We have added § 413.86(e)(1)(iii) to clarify that if the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885, the intermediary may modify the hospital's base period costs solely for purposes of computing the per resident amount.
- We have revised § 413.86(e)(4) (proposed § 413.86(c)(5)) to provide that the base period for determining per resident amounts in hospitals that begin a GME program after the base period will be the first cost reporting period in which residents were on duty in their GME program during the first month of the cost reporting period.
- We have modified § 413.86(e)(4)(ii) to provide that daily averages are multiplied by the number of days in a year to achieve a more equitable base-period average per resident amount.
- We have moved to § 413.86(e)(5) the policy proposed in paragraph (e)(4) regarding the determination of per resident amounts for hospitals that did not participate or have an approved medical residency training program during the base period.
- We have modified § 413.86(f) so as to include in the FTE count residents who are working in a Medicare hospital even if the residents' salaries are fully paid by other entities, either Federal or nonFederal. This revised counting policy will apply to both the GME base period and cost reporting periods subject to the new payment methodology. We have also revised § 413.86(f) to specify how part-time interns and interns on rotation will be counted.
- We have added a new subparagraph (h)(4) to § 413.86 to state that, beginning on September 1, 1989, passage of both parts of the National Board of Medical Examiners Examination may be substituted for passage of FMGEMS.
- We have moved to § 413.86(f)(1)(iii) the policy proposed in § 413.86(g)(4), effective July 1, 1987, concerning the time spent in nonprovider settings.
- We clarify in new § 413.86(j) that hospitals that are excluded from the prospective payment system may request to have their target amount recomputed to reflect misclassified costs in the same way prospective payment hospitals may request to have their HSRs recomputed. We also clarify that the adjustment to the HSR is effective for the hospital's cost reporting periods that are still subject to reopening under § 405.1885.

V. Regulatory Impact Analysis

A. Introduction

Executive Order 12291 (E.O. 12291) requires us to prepare and publish a regulatory impact analysis for any rule that meets one of the E.O. criteria for a "major rule"; that is, a rule that will be likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

In addition, we generally prepare a final regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless the Secretary certifies that a final regulation will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we treat all hospitals as small entities. Also, section 1102(b) of the Social Security Act requires the Secretary to prepare a final regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 50 beds located outside of a Metropolitan Statistical Area.

The following discussion, in combination with the rest of this final rule, constitutes a combined regulatory impact analysis and regulatory flexibility analysis. However, because there are so few small rural hospitals with approved GME programs, we have determined, and the Secretary certifies that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

B. Affected Entities

We estimate that approximately 1,170 acute care hospitals in the 50 States and in Puerto Rico have approved programs for which they are receiving Medicare payment for GME costs. In 1987, there were approximately 81,000 interns and residents enrolled in approved programs.

The following table shows the distribution by census division of short-term acute care hospitals with approved GME programs, residents enrolled in GME programs and GME programs approved as of September 1, 1987.

TABLE I—PERCENT OF ACUTE CARE HOSPITALS WITH APPROVED GME PROGRAMS IN FY 1987, RESIDENTS ON DUTY ON SEPTEMBER 1, 1987, AND APPROVED GME PROGRAMS BY CENSUS DIVISION

	Teaching hospitals	Residents [1]	Approved programs [1]
New England	6.7	7.4	8.0
Middle Atlantic	22.1	23.8	23.3
South Atlantic	12.4	15.2	15.2
East North Central	21.7	17.3	17.0
East South Central	5.1	4.3	4.6
West North Central	8.3	6.8	6.5
West South Central	8.0	8.8	8.9
Mountain	3.6	3.1	3.4
Pacific	11.0	12.2	12.0
Puerto Rico	1.2	1.1	1.1
Total	[2] 100.1	100.0	100.0

[1] Source: 1988–1989 Directory of Graduate Medical Education Programs; Accredited by the Accreditation Council for Graduate Medical Education. Reproduced with permission of the copyright holder, the American Medical Association.

[2] Total does not add to 100 percent due to rounding.

Table I shows that the distributions of teaching hospitals, residents, and approved GME programs parallel each other fairly closely. The Middle Atlantic division has the greatest number of teaching hospitals, residents, and GME programs while the Mountain census division has the smallest number of teaching hospitals, residents, and programs.

It should be noted that while Table I presents only general acute care hospitals (primarily those hospitals under the prospective payment system), these regulations will apply to all participating Medicare hospitals and health care complexes having residents. These include long-term care hospitals, children's hospitals, psychiatric facilities, and rehabilitation hospitals.

C. Savings

These final regulations will implement the statutory requirement to control the growth in payments to hospitals with currently approved GME programs by limiting payment increases for direct GME costs to increases in the CPI–U, rather than paying these costs on the basis of the hospital's allowable reasonable costs. We also expect to achieve some small savings by reducing

the per resident amount paid for residents not in an initial residency period. The following table presents the estimated savings expected to be achieved from implementing this final rule, relative to what we estimate would have been paid for the direct cost of GME under Medicare reasonable cost principles. The statutory provision requiring this regulation effectively negated the July 5, 1985, regulation that placed cost limits on GME payments and which would have resulted in greater savings than those shown below.

TABLE II—MEDICARE PROGRAM SAVINGS *

[In millions]

FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
$500	$430	$370	$470	$580

* Rounded to the nearest $10 million.

Since this final rule is effective retroactively from July 1, 1985, we will be making adjustments to hospital GME payments made between July 1, 1985, and the date this final rule is published. These adjustments reflect differences in payments made under the previous payment rules formerly located at § 413.85 and this final rule. The savings shown in Table II, above, include retroactive annual savings of $290 million we expect to recoup in FY 1990 and $150 million in FY 1991. (In the proposed rule, we had assumed that the retroactive savings would be recouped in FYs 1989–1991.) In Table III, we present these same retroactive savings displayed by fiscal year (FY 1985 to the present) in which these amounts were generated.

TABLE III—ESTIMATED RETROACTIVE MEDICARE PROGRAM SAVINGS BY FISCAL YEAR IN WHICH THEY WERE GENERATED*

[In millions]

FY 1985	FY 1986	FY 1987	FY 1988	FY 1989
$10	$30	$120	$120	$160

*Rounded to the nearest $10 million.

These savings estimates were computed using the method of apportioning GME costs prescribed by section 1886(h)(3) of the Act. That is, we compared the GME payments made under the previous payment method with those that will be made under the new payment method using inpatient days as the basis of apportioning GME costs between Medicare and non-Medicare payment sources. This approach to computing the savings estimates differs from the way we computed savings in the initial impact analysis. In the initial analysis, we computed savings based on the method of apportioning GME costs prescribed by the Provider Reimbursement Manual (HCFA Pub. 15—Part II). Under these procedures, only routine service and special care costs are apportioned on the basis of inpatient days. Ancillary and outpatient costs are apportioned on the basis of charges. Had we computed savings using the cost report method of apportioning GME costs to Medicare, we would have overstated savings for the next five fiscal years by about $440 million.

Although this rule implements provisions to substantially reduce Medicare payments for GME, it is difficult to predict the effects these reductions will have on specific GME programs. We know that patient revenues generally comprise the major portion of GME funding, but the proportion of funding varies depending on a hospital's affiliation and the speciality programs the hospital operates. State-run hospitals, for example, depend less on patient revenues than do unaffiliated or church-affiliated hospitals. Also, oncology GME programs tend to receive more funding from sources other than patient revenues (that is, from grants and gifts) than GME programs in family practice medicine.

A critical factor in determining the impact of these regulations is the proportion of Medicare revenues a hospital received in its base period. The lower the proportion of Medicare revenues received in the base period, the smaller will be the impact of the new payment rules on the hospital's funding of its GME programs. Conversely, the greater the proportion of Medicare revenues received in its base period, the greater will be the effect of the new payment rules.

D. Alternatives Considered

Prior to the enactment of section 9202 of Public Law 99–272, we had considered several alternatives that were based on the July 5, 1985 final rule establishing a ceiling on payment for all direct medical education expenses. The alternatives would have maintained the ceiling for either 1 or 2 more years and then permitted the payment amount to increase by the CPI–U. Also, we considered eliminating all payment for nursing and allied health professional education programs. Section 1886(h) of the Act enacted by section 9202 of Public Law 99–272 precluded further consideration of these alternatives.

Under E.O. 12291 and the RFA we are also required to consider the consequences of not taking the action. The consequence of not issuing the final rule will be the failure to implement duly enacted legislation. The changes to provide payments based on the number of residents employed full-time in initial residency programs are mandated by statute.

E. Discussion of Public Comments

In response to the impact analysis in the proposed rule we received two timely items of correspondence. The comments and our responses to them are set forth below.

Comment: One commenter indicated that the preamble to the proposed rule should have discussed in greater detail the impact of the 5-year limitation on Medicare payments for residency programs of longer duration. The commenter also believes that it will be more difficult for teaching hospitals to obtain alternative funding to replace reduced Medicare participation than is indicated in the Regulatory Impact Analysis.

Response: We should first point out that the payment methodology set forth in section 1886(h) of the Act does not end payments for residents in approved programs after their fifth residency year but merely reduces the payments due to the reduction in the weighting factors for residents who are not in their initial residency periods. Further, we believe that it would be difficult to argue that the Medicare program, with its multiple types of payments in response to various aspects of GME, has not been receptive to financing of GME programs. We believe that the enactment of section 1886(h) of the Act was a clear statement from Congress that a limitation on the growth in Medicare GME expenditures was necessary. Further, although not explicitly stated, it reflects a decision on the part of Congress to focus reductions on subspecialty programs beyond the initial residency period rather than on primary care programs.

We believe that a more appropriate organization to assess in greater detail the impact of this change is the Council on Graduate Medical Education established by Congress to make recommendations on various aspects of GME training. HCFA does not possess the expertise to assess the long-term impact of its financing mechanisms on the training of physicians. Our role is to administer the Medicare program under the laws as passed by Congress.

Comment: A State hospital association suggested that it would be helpful if all proposed rules contain a financial impact by State in order that

an appropriate analysis could be assessed.

Response: We have not adopted the commenter's suggestion for two reasons. First, the data available to us, in many instances, are either incomplete or inaccurate. At a regional (census division) or national level of aggregation, the effects of these deficiencies are diminished because errors have a greater probability of being distributed normally throughout the data. Thus, errors in the data will tend to cancel each other out in the aggregate.

Also errors in a large sample will have less of an impact on statistics drawn from that sample than would errors in a small sample because of the smaller weight each value has in the large sample. Thus, erroneous or missing values will have less of an effect on a large sample than they would on a small sample. It then also follows that any conclusions drawn from a small data set have a higher probability of being wrong than do conclusions drawn from a large data set.

The second reason for not constructing an impact analysis by State has to do with policy consideration. To develop an impact analysis for each State, we believe, would be inconsistent with the national character of the Medicare program. In contrast to the Medicaid program (which is under the administrative control of each State Medicaid agency), the Medicare program is under direct control of the Federal government, and therefore, the concerns and goals of the Medicare program are national in scope. Nevertheless, when our data permit a reasonably accurate analysis, we have presented impacts of proposed and final rules by census division and by locations in urban or rural areas. Yet, because of the data limitations and the national character of the Medicare program, we believe that formulating an analysis for each State is inappropriate.

F. Conclusion

This rule is expected to significantly reduce payments to hospitals for their GME programs, principally through controlling the rate at which these payments increase. It is difficult, however, to predict which hospitals will be significantly affected and how hospitals will respond to this rule.

VI. Circumstances Require Retroactive Application of this Final Rule

Pursuant to Congress's mandate in section 9202(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99–272), this regulation is effective for cost reporting periods beginning on or after July 1, 1985. We believe that we are required by law to apply this rule retroactively to all cost reports for cost reporting periods beginning on or after the effective date prescribed by Congress.

A. Congress Has Required Retroactive Application of this Rule

The language of the statute unambiguously requires the retroactive application of this regulation. The statute expressly requires that the new payment method for direct medical education costs be applied "to hospital cost reporting periods beginning on or after July 1, 1985." Moreover, the statutory language expressly provides for a "*Substitution* of Special Payment Rules," substituting a new payment method for the method already in place, a method that was to be applicable for cost reporting periods beginning on or after July 1, 1985. Section 9202(a) of Public Law 99–272 *enacting* section 1886(h)(1) of the Act (emphasis added). In addition, the description of the new payment method set forth at 9202(a) of Public Law 99–272 is replete with Congressional references to July 1, 1985 as the date upon which the Secretary is to begin applying that new method. *See* § 9202(a) of Public Law 99–272 *enacting* sections 1886 (h)(2), (h)(2)(C) and (h)(3)(A) of the Act; *see also* section 9202(i) of Public Law 99–272 *amending* section 1861(v)(1)(A) of the Act.

This straightforward statutory language is, moreover, simply a manifestation of Congress's clear intent that this implementing regulation be applied retroactively. That intent is demonstrated by the fact that Congress's enactment of the new payment regime for direct medical education costs itself had a retroactive effect. The new payment method was enacted on April 1, 1986, over nine months after the beginning of the cost reporting period to which it was first applicable. In addition, with the enactment of this new method, Congress deliberately foreclosed the possibility of making payment for direct medical education costs under the payment methodology previously in effect for cost periods beginning on or after July 1, 1985. That method was based on a final rule, promulgated by the agency on July 5, 1985, that placed a one year limit on medical education costs for cost reporting periods beginning on or after July 1, 1985 but before July 1, 1986. With the passage of section 9202 of Public Law 99–272, Congress nullified the payment method embodied in the agency's 1985 regulation (section 9202(i) of Public Law 99–272) and replaced it with a detailed payment method of its own devising.

The legislative history accompanying section 9202 of Public Law 99–272 makes it clear that Congress intended to repeal the previous system of direct medical education cost payment beginning on July 1, 1985. The Conference Report states that the "methodology [prescribed in section 9202(a) of Pub. L. 99–272] replaces the current reasonable cost methodology for determining hospitals allowable costs, in calculating hospitals' medicare payments for graduate medical education activities." See H.R. Rep. No. 453, 99th Cong., 1st Sess. 484 (1985).

Thus, for cost reporting periods beginning on or after July 1, 1985, HCFA has no authority to make final payment to providers under the previous method; HCFA is only authorized to make payment for direct medical education costs on the basis of the method prescribed by Congress in section 9202 of Pub. L. 99–272. In repealing the regulation that previously governed medical education payment for cost reporting periods beginning on or after July 1, 1985, Congress must have intended its new method to apply to that period instead. Consequently, in order to give effect to the intent of Congress, the agency must apply this regulation retroactively. Given the express language of the statute, the fact that the statute itself has retroactive effect and the lack of legal authority to settle cost reports beginning on or after July 1, 1985 on the basis of the old payment method, it is clear that Congress intended that this regulation be applied retroactively.

B. Retroactive Application of This Rule Is Consistent With the Supreme Court's Decision in Bowen v. *Georgetown University Hospital*

We believe that retroactive application of this regulation is not only mandated by Congress but that it is also consistent with *Bowen* v. *Georgetown University Hospital*, 109 S. Ct. 468 (1988) ("*Georgetown*"), the recent Supreme Court decision on retroactive rulemaking. *Georgetown* involved a retroactive application of a cost limits regulation that the agency contended was authorized by section 1861(v)(1)(A)(ii) of the Act, permitting "retroactive corrective adjustments" to Medicare cost reports. However, the Supreme Court held that an agency may not apply a regulation retroactively without the authorization of Congress, *Georgetown*, 109 S. Ct. at 471, and that the Medicare Act's corrective adjustment provision did not authorize

the retroactive application of the cost limits rule.

Thus, the *Georgetown* decision holds that there must be some sort of Congressional authorization for the promulgation of retroactive rules. However, *Georgetown* does not require an express grant of Congressional authority in each case in which an agency seeks to apply a regulation retroactively. Rather, such an express grant is only required as an aid in construing a general grant of rulemaking authority such as section 1861(v)(1)(A) of the Act or the Administrative Procedure Act. Where other Congressional enactments (such as section 9202 of Public Law 99–272) are relied upon as authority for retroactive application, it need only be shown that the "language requires" retroactive application. Such language need not contain an express authorization. Rather, the authorization may be implicit; it may be evident only upon reading the language of the statute in light of the circumstances surrounding the enactment of that language. *See, for example, Georgetown*, 109 S. Ct. at 479–80. Nevertheless, even if *Georgetown* were to be read as requiring express authority at all times, it is clear that section 9202 of Public Law 99–272 provides such express authority.

The *Georgetown* court also held that congressional enactments other than general grants of rulemaking authority will be construed to authorize retroactive application where their "language requires this result." Here the agency is not relying on our general grant of rulemaking authority to support retroactive application, but, rather, on a specific congressional enactment, that is, section 9202 of Public Law 99–272. As demonstrated above, the plain language of section 9202 of Public Law 99–272, the fact that section 9202 of Public Law 99–272 itself has retroactive effect and the repeal of the previous payment rule all require the retroactive application of this regime. Accordingly, it is clear that retroactive application of this regulation is supported by the Supreme Court's ruling in *Georgetown*.

The concurring opinion in *Georgetown* explains in more detail the circumstances under which retroactive application of an informal rule is permitted and, in doing so, provides even stronger support for retroactive application of this medical education regulation. In his concurrence, Justice Scalia notes that "a particular statute may in some circumstances implicitly authorize retroactive rulemaking." He explains that "if a statute prescribes a deadline by which particular rules must be in effect, and if the agency misses the deadline, the statute may be interpreted to authorize a reasonable retroactive rule * * *." Justice Scalia's example is analogous to the situation here in which Congress has prescribed a specific effective date for the operation of the new payment system and that date has passed before the promulgation of the implementing regulation. Indeed, that date passed before the enactment of the statute. Clearly, under Justice Scalia's analysis, Congress must be deemed to have at least implicitly authorized retroactive application of this medical education regulation. In any event, the retroactive application of this medical education regulation is plainly supported by the majority opinion in *Georgetown*.

C. Equitable Considerations Also Support the Retroactive Application of This Rule

Retroactive application of this rule is not only supported by *Georgetown* but by several equitable considerations as well. Section 9202 of Public Law 99–272 explicitly states that the new payment method is effective for cost reporting periods beginning on or after July 1, 1985. Since enactment of section 9202 of Public Law 99–272, all of HCFA's actions respecting direct medical education costs have been consistent with its stated intention to apply the new payment method beginning on the effective date of the new statute. For example, on May 6, 1986 (at 51 FR 16776), HCFA announced that it planned to publish regulations implementing section 9202 of Public Law 99–272 that would be designed to replace the old payment method for medical education costs for cost reporting periods beginning on or after July 1, 1985. During this period, and the fiscal intermediaries have informed providers that the new payment method would be applied to those costs.

In addition, because this regulation is largely self-implementing and the Secretary has had little discretion in crafting it, it contains few, if any, innovations or deviations from the Congressionally-prescribed scheme that could come as a surprise to providers. Therefore, affected providers have known since at least the date of the enactment of Public Law 99–272 of the details of the new payment method and of the fact that this new method would be applied retroactively.

Finally, failure to apply this regulation retroactively will result not only in a failure to effect Congress's intent but will also result in a windfall to the affected providers. To the extent that they have received greater interim payments based on the old payment method than they will receive under the new payment method, providers have, in effect, received an interest-free advance of Medicare funds that Congress clearly intended them not to retain. It would be egregiously inequitable to permit providers to reap this windfall, estimated to be $570 million, especially since they have been on notice that they would not be entitled to retain these funds.

VII. Other Required Information

A. Paperwork Burden

Under section 9202(h) of Public Law 99–272, information required for purposes of implementation of the new section 1886(h) of the Act, as enacted by Public Law 99–272, is not subject to the requirements of the Paperwork Reduction Act of 1980 (44 U.S.C. Chapter 35). Other provisions of this final rule do not contain reporting requirements. Therefore, it is not necessary that the rule be reviewed by the Office of Management and Budget under the latter Act.

B. List of Subjects

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 412

Health facilities, Medicare.

42 CFR Part 413

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Nursing homes, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR chapter IV is amended as set forth below:

A. Part 405, subpart E is amended as set forth below:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

Subpart E—Criteria for Determination of Reasonable Charges; Reimbursement for Services for Hospital Interns, Residents, and Supervisory Physicians

1. The authority citation for part 405, subpart E continues to read as follows:

Authority: Secs. 1102, 1814(b), 1832, 1833(a), 1842 (b) and (h), 1861 (b) and (v), 1862(a)(14),

1866(a), 1871, 1881, 1886 and 1887 of the Social Security Act as amended (42 U.S.C. 1302, 1395f(b), 1395k, 1395l(a), 1395u (b) and (h), 1395x (b) and (v), 1395y(a)(14), 1395cc(a), 1395hh, 1395rr, 1395ww and 1395xx).

2. In § 405.521, the last sentence of paragraph (a) and the last two sentences of paragraph (d)(1) are removed; at the end of the last sentence of amended paragraph (d)(1) the phrase, "as described in § 413.86." is inserted; paragraphs (d)(2) and (d)(3) are revised to read as follows; and in paragraph (e), the phrase "health insurance" is replaced with the word "Medicare":

§ 405.521 Services of attending physicians supervising interns and residents.

* * * * *

(d) * * *

(2) For cost-reporting periods beginning after June 30, 1973, a hospital with an approved teaching program (see § 405.522(a)) may elect to receive reimbursement on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of any payment on the basis of reasonable charges that might otherwise be payable for such services. A hospital may make this election to receive cost reimbursement only if all physicians who furnish services in the hospital that are covered under Medicare agree not to bill charges for such services (or if all the physicians are employees of the hospital and as a condition of employment they are precluded from billing for such services). If the requirements of this paragraph (d)(2) are satisfied by a hospital, the reimbursement provisions of § 405.465 are applicable.

(3) For cost reporting periods beginning on or after July 1, 1985, a teaching hospital that elects payment for the direct medical and surgical services of its physicians in accordance with paragraph (d)(2) of this section must, for purposes of calculating the per resident amounts described in § 413.86(e) of this chapter, remove from its graduate medical education base period costs, as defined in § 483.86(d) of this chapter, those costs relating to the supervision of interns and residents in approved programs related to the care of individual patients.

* * * * *

§ 405.522 [Amended]

3. In § 405.522, the phrase "Council on Medical Education" in paragraph (a) is replaced by the phrase "Accreditation Council for Graduate Medical Education".

B. Part 412, subpart H is amended as set forth below:

PART 412—PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

Subpart H—Payments to Hospitals Under the Prospective Payment System

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102, 1122, 1815(e), 1871, and 1886 of the Social Security Act (42 U.S.C. 1302, 1320a–1, 1395g(e), 1395hh, and 1395ww).

2. In § 412.113, paragraph (b) is revised to read as follows:

§ 412.113 Payments determined on a reasonable cost basis.

* * * * *

(b) *Direct medical education costs.* (1) Payment for the direct medical education costs of interns and residents in approved programs for cost reporting periods beginning prior to July 1, 1985, and for approved education activities of nurses and paramedical health professionals is made as described in § 413.85 of this chapter.

(2) For cost reporting periods beginning on or after July 1, 1985, payment for the direct medical education costs of interns and residents in approved programs is made as described in § 413.85 of this chapter.

(3) Except as provided in § 413.86(c)(1) of this chapter, for cost reporting periods during the prospective payment transition period, the costs of medical education must be determined in a manner that is consistent with the treatment of these costs for purposes of determining the hospital-specific portion of the payment rate as provided in subpart E of this part.

C. In part 413, subparts A, F, and H are amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES

A. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1122, 1814(b), 1815, 1833(a), 1861(v), 1871, 1881, and 1886 of the Social Security Act as amended (42 U.S.C. 1302, 1320a–1, 1395f(b), 1395g, 1395l(a), 1395x(v), 1395hh, 1395rr and 1395ww).

B. In subpart A, § 413.13, the introductory text of paragraph (d) is republished; paragraphs (d)(3) and (d)(4) are revised; a new paragraph (d)(5) is added; the introductory text of paragraph (f)(2) is republished; and a new paragraph (f)(2)(iii)(C) is added to read as follows:

Subpart A—Introduction and General Rules

§ 413.13 Amount of payment if customary charges for services furnished are less than reasonable costs.

* * * * *

(d) *Exclusions from reasonable cost.* For purposes of comparison with customary charges under this section, reasonable cost does not include—

* * * * *

(3) Amounts that result from a disposition of depreciable assets (§ 413.134(f)), applicable to prior cost reporting periods;

(4) Payments to funds for the donated services of teaching physicians (§ 413.85); and

(5) Graduate medical education costs for cost reporting periods beginning on or after July 1, 1985.

* * * * *

(f) *Nominal charges.* * * *

(2) *Cost reporting periods beginning on or after October 1, 1984.* For cost reporting periods beginning on or after October 1, 1984, the following provisions apply in determining nominal charges:

* * * * *

(iii) *Determination of nominal charges in special situations.* * * *

(C) For cost reporting periods beginning on or after July 1, 1985, graduate medical education payments (or a provider's graduate medical education reasonable costs if supported by appropriate data) are included in reasonable costs when making the nominal charge determination.

* * * * *

C. Subpart F is amended as follows:

Subpart F—Specific Categories of Costs

1. In § 413.85, paragraphs (a) and (e) are revised to read as follows:

§ 413.85 Cost of educational activities.

(a) *Payment*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, a provider's allowable cost may include its net cost of approved educational activities, as calculated under paragraph (g) of this section. The net cost is subject to apportionment based on Medicare utilization as described in § 413.50.

(2) *Exception.* For cost reporting periods beginning on or after July 1, 1985, payment to hospitals and hospital-based providers for approved residency programs in medicine, osteopathy, dentistry, and podiatry is determined as provided in § 413.86.

* * * * *

(e) *Approved programs.* Recognized professional and paramedical educational training programs now being conducted by provider institutions, and their approving bodies, include the following:

(1) Cytotechnology	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(2) Dietetic internships.	The American Dietetic Association.
(3) Hospital administration residencies.	Accrediting Commission on Education in Health Services Administration.
(4) Inhalation therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Inhalation Therapy.
(5) Medical records.	Committee on Allied Health, Education, and Accreditation in collaboration with the Committee on Education and Registration of the American Association of Medical Records Librarians.
(6) Medical technology.	Committee on Allied Health, Education, and Accreditation in collaboration with the Board of Schools of Medical Technology, American Society of Clinical Pathologists.
(7) Nurse anesthetists.	The American Association of Nurse Anesthetists.
(8) Professional nursing.	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(9) Practical nursing.	Approved by the respective State approving authorities. Reported for the United States by the National League for Nursing.
(10) Occupational Therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the Council on Education of the American Occupational Therapy Association.
(11) Pharmacy residencies.	American Society of Hospital Pharmacists.
(12) Physical therapy.	Committee on Allied Health, Education, and Accreditation in collaboration with the American Physical Therapy Association.
(13) X-ray technology.	Committee on Allied Health, Education, and Accreditation in collaboration with the American College of Radiology.

* * * * *

2. A new § 413.86 is added to read as follows:

§ 413.86 Direct graduate medical education payments.

(a) *Statutory basis and scope*—(1) *Basis.* This section implements section 1886(h) of the Act by establishing the methodology for Medicare payment of the cost of direct graduate medical educational activities.

(2) *Scope.* This section applies to Medicare payments to hospitals and hospital-based providers for the costs of approved residency programs in medicine, osteopathy, dentistry, and podiatry for cost reporting periods beginning on or after July 1, 1985.

(b) *Definitions.* For purposes of this section, the following definitions apply:

"Approved geriatric program" means a fellowship program of one or more years in length that is approved by the Accreditation Council for Graduate Medical Education (ACGME) under the ACGME's criteria for geriatric fellowship programs in internal medicine and family practice.

"Approved medical residency program" means a program that meets one of the following criteria:

(1) Is approved by one of the national organizations listed in § 405.522(a) of this chapter.

(2) May count towards certification of the participant in a specialty or subspecialty listed in the *Directory of Residency Training Programs* published by the American Medical Association.

(3) Is approved by the Accreditation Council For Graduate Medical Education (ACGME) as a fellowship program in geriatric medicine.

"Base period" means a cost reporting period that began on or after October 1, 1983 but before October 1, 1984.

"CPI—U" stands for the Consumer Price Index for All Urban Consumers as compiled by the Bureau of Labor Statistics.

"Foreign medical graduate" means a resident who is not a graduate of a medical, osteopathy, dental, or podiatry school, respectively, accredited or approved as meeting the standards necessary for accreditation by one of the following organizations:

(1) The Liaison Committee on Medical Education of the American Medical Association.

(2) The American Osteopathic Association.

(3) The Commission on Dental Accreditation.

(4) The Council on Podiatric Medical Education.

"FMGEMS" stands for the Foreign Medical Graduate Examination in the Medical Sciences (Days I and II).

"FTE" stands for full-time equivalent.

"Medicare patient load" means, with respect to a hospital's cost reporting period, the total number of hospital inpatient days during the cost reporting period that are attributable to patients for whom payment is made under Medicare Part A divided by total hospital inpatient days. In calculating inpatient days, inpatient days in any district part of the hospital furnishing a hospital level of care are included and nursery days are excluded.

"Resident" means an intern, resident, or fellow who participates in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board.

(c) *Payment for graduate medical education costs—General rule.* Beginning with cost reporting periods starting on or after July 1, 1985, hospitals, including hospital-based providers, are paid for the costs of approved graduate medical education programs as described in paragraph (d) through (h) of this section.

(d) *Calculating payment for graduate medical education costs.* A hospital's Medicare payment for the costs of an approved residency program is calculated as follows:

(1) *Step one.* The hospital's updated per resident amount (as determined under paragraph (e) of this section) is multipled by the actual number of FTE residents (as determined under paragraph (g) of this section). This result is the aggregate approved amount for the cost reporting period.

(2) *Step two.* The product derived in step one is multipled by the hospital's Medicare patient load.

(3) *Step three.* The product derived in step two is apportioned between Part A and Part B of Medicare based on the ratio of Medicare's share of reasonable costs excluding graduate medical education costs attributable to each part as determined through the Medicare cost report.

(e) *Determining per resident amounts for the base period*—(1) *For the base period.* (i) Except as provided in paragraph (e)(4) of this section, the intermediary determines a base-period per resident amount for each hospital as follows:

(A) Determine the allowable graduate medical education costs for the cost reporting period beginning on or after October 1, 1983 but before October 1, 1984. In determining these costs, graduate medical education costs allocated to the nursery cost center, research and other nonreimbursable cost centers, and hospital-based providers that are not participating in Medicare are excluded and graduate medical education costs allocated to distinct-part hospital units and hospital-based providers that participate in Medicare are included.

(B) Divide the costs calculated in paragraph (e)(1)(i)(A) of this section by the average number of FTE residents working in all areas of the hospital complex (including those areas whose costs were excluded under paragraph (e)(1)(i)(A) of this section) for its cost reporting period beginning on or after October 1, 1983 but before October 1, 1984.

(ii) In determining the base-period per resident amount under paragraph (e)(1)(i) of this section, the intermediary—

(A) Verifies the hospital's base-period graduate medical education costs and the hospital's average number of FTE residents;

(B) Excludes from the base-period graduate medical education costs any nonallowable or misclassified costs, including those previously allowed under § 412.113(b)(3) of this chapter; and

(C) Upon a hospital's request, includes graduate medical education costs that were misclassified as operating costs during the hospital's prospective payment base year and were not allowable under § 412.113(b)(3) of this chapter during the graduate medical education base period. These costs may be included only if the hospital requests an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(iii) If the hospital's cost report for its GME base period is no longer subject to reopening under § 405.1885 of this chapter, the intermediary may modify the hospital's base-period costs solely for purposes of computing the per resident amount.

(iv) If the intermediary modifies a hospital's base-period graduate medical education costs as described in paragraph (e)(1)(ii)(B) of this section, the hospital may request an adjustment of its prospective payment hospital-specific rate or target amount as described in paragraph (j)(2) of this section.

(v) The intermediary notifies each hospital that either had direct graduate medical education coats or received indirect education payment in its cost reporting period beginning on or after October 1, 1984 and before October 1, 1985 of its base-period average per resident amount. A hospital may appeal this amount within 180 days of the date of that notice.

(2) *For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986.* For cost reporting periods beginning on or after July 1, 1985 and before July 1, 1986, a hospital's base-period per resident amount is adjusted as follows:

(i) If a hospital's base period began on or after October 1, 1983 and before July 1, 1984, the amount is adjusted by the percentage change in the CPI–U that occurred between the hospital's base period and the first cost reporting period to which the provisions of this section apply. The adjusted amount is then increased by one percent.

(ii) If a hospital's base period began on or after July 1, 1984 and before October 1, 1984, the amount is increased by one percent.

(3) *For cost reporting periods beginning on or after July 1, 1986.* For cost reporting periods beginning on or after July 1, 1986, each hospital's per resident amount for the previous cost reporting period is adjusted by the projected change in the CPI–U for the 12-month cost reporting period. This adjustment is subject to revision during the settlement of the cost report to reflect actual changes in the CPI–U that occurred during the cost reporting period.

(4) *Exceptions*—(i) *Base period for certain hospitals.* If a hospital did not have any approved medical residency training programs or did not participate in Medicare during the base period, but either condition changes in a cost reporting period beginning on or after July 1, 1985, the intermediary establishes a per resident amount for the hospital using the information from the first cost reporting period during which the hospital participates in Medicare and the residents are on duty during the first month of that period. Any graduate medical education program costs incurred by the hospital before that cost reporting period are reimbursed on a reasonable cost basis. The per resident amount is based on the lower of the following:

(A) The hospital's actual costs, incurred in connection with the graduate medical education program for the hospital's first cost reporting period in which residents were on duty during the first month of the cost reporting period.

(B) The mean value of per resident amounts of hospitals located in the same geographic wage area, as that term is used in the prospective payment system under Part 412 of this chapter, for cost reporting periods beginning in the same fiscal years. If there are fewer than three amounts that can be used to calculate the mean value, the intermediary must contact HCFA Central Office for a determination of the appropriate amount to use.

(ii) *Short or long base-period cost reporting periods.* If a hospital's base-period cost reporting period reflects graduate medical education costs for a period that is shorter than 50 weeks or longer than 54 weeks, the intermediary converts the allowable costs for the base period into a daily figure. The daily figure is then multiplied by 365 or 366, as appropriate, to derive the approved per resident amount for a 12-month base-period cost reporting period. If a hospital has two cost reporting periods beginning in the base period, the later period serves as the base-period cost reporting period.

(iii) *Short or long cost reporting periods beginning on or after July 1, 1985.* If a hospital's cost reporting period is shorter than 50 weeks or longer than 54 weeks, the hospital's intermediary should contact HCFA Central Office to receive a special CPI–U adjustment factor.

(f) *Determining the total number of FTE residents.* (1) Subject to the weighting factors in paragraphs (g) and (h) of this section, the count of FTE residents is determined as follows:

(i) Residents in an approved program working in all areas of the hospital complex may be counted.

(ii) No individual may be counted as more than one FTE. If a resident spends time in more than one hospital or, except as provided in paragraph (f)(1)(iii) of this section, in a nonprovider setting, the resident counts as a partial FTE based on the proportion of time worked at the hospital to the total time worked. A part-time resident counts as a partial FTE based on the proportion of time worked as compared to the average time spent by other residents working in the same specialty program.

(iii) On or after July 1, 1987, the time residents spend in nonprovider settings such as freestanding clinics, nursing homes, and physicians' offices in connection with approved programs is not excluded in determining the number of FTE residents in the calculation of a hospital's resident count if the following conditions are met:

(A) The resident spends his or her time in patient care activities.

(B) There is a written agreement between the hospital and the outside entity that states that the resident's compensation for training time spent outside of the hospital setting is to be paid by the hospital.

(2) To include a resident in the FTE count for a particular cost reporting period, the hospital must furnish the following information.

The information must be certified by an official of the hospital and, if different, an official responsible for administering the residency program.

(i) The name and social security number of the resident.

(ii) The type of residency program in which the individual participates and the number of years the resident has completed in all types of residency programs.

(iii) The dates the resident is assigned to the hospital and any hospital-based providers.

(iv) The dates the resident is assigned to other hospitals, or other freestanding providers, and any nonprovider setting during the cost reporting period, if any.

(v) The name of the medical, osteopathic, dental, or podiatric school from which the resident graduated and the date of graduation.

(vi) If the resident is an FMG, documentation concerning whether the resident has satisfied the requirements of paragraph (h) of this section.

(vii) The name of the employer paying the resident's salary.

(g) *Determining the weighted number of FTE residents.* Subject to the provisions in paragraph (h) of this section, HCFA determines a hospital's number of FTE residents by applying a weighting factor to each resident and then summing the resulting numbers that represent each resident. The weighting factor is determined as follows:

(1) For purposes of this section, an initial residency period is the number of years necessary to satisfy the minimum requirements for certification in a specialty or subspecialty, plus one year. An initial residency period may not exceed five years in order to be counted toward determining FTE status except in the case of fellows in an approved geriatric program whose initial residency period may last up to two additional years.

(i) For residency programs other than those specified in paragraphs (g)(1)(ii) and (g)(1)(iii) of this section, the initial residency period is the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training, as specified in the 1985–1986 Directory of Residency Training Programs.

(ii) For residency programs in osteopathy, dentistry, and podiatry, the minimum requirement for certification in a specialty or subspecialty is the minimum number of years of formal training necessary to satisfy the requirements of the appropriate approving body listed in § 405.522(a) of this chapter.

(iii) For residency programs in geriatric medicine approved by the ACGME, as set forth in later editions of the directory specified in paragraph (g)(1)(ii) of this section, these programs are considered approved programs retroactively to the latter of—

(A) The starting date of the program within a hospital; or

(B) The hospital's costs reporting period beginning on or after July 1, 1985.

(iv) The time spent in residency programs that do not lead to certification in a specialty or subspecialty, but that otherwise meet the definition of approved programs, as described in paragraph (b) of this section, is counted toward the initial residency period limitation.

(2) If the resident is in an initial residency period, the weighting factor is one.

(3) If the resident is not in an initial residency period, the weighting factor is 1.00 during the period beginning on or after July 1, 1985 and before July 1, 1986, .75 during the period beginning on or after July 1, 1986 and before July 1, 1987 and is .50 thereafter without regard to the hospital's cost reporting period.

(h) *Determination of weighting factors for foreign medical graduates.* (1) The weighting factor for a foreign medical graduate is determined under the provisions of paragraph (g) of this section if the foreign medical graduate—

(i) Has passed FMGEMS; or

(ii) Before July 1, 1986, received certification from, or passed an examination of, the Educational Committee for Foreign Medical Graduates.

(2) Before July 1, 1986, the weighting factor for a foreign medical graduate is 1.0 times the weight determined under the provisions of paragraph (g) of this section. On or before July 1, 1986 and before July 1, 1987, the weighting factor who does not meet the requirements set forth in paragraph (h)(1) of this section is .50 times the weight determined under the provisions of paragraph (g) of this section.

(3) On or after July 1, 1987, these foreign medical graduates are not counted in determining the number of FTE residents.

(4) During the cost reporting period in which a foreign medical graduate passes FMGEMS, the weighting factor for that resident is determined under the provisions of paragraph (g) of this section for the part of the cost reporting period beginning with the month the resident passes the test.

(5) On or after September 1, 1989, the National Board of Medical Examiners Examination, Parts I and II, may be substituted for FMGEMS for purposes of the determination made under paragraphs (h)(1) and (h)(4) of this section.

(i) *Special rules for States that formerly had a waiver from Medicare reimbursement principles.* (1) Effective for cost reporting periods beginning on or after Janaury 1, 1986, hospitals in States that, prior to becoming subject to the prospective payment system, had a waiver for the operation of a State reimbursement control system under section 1886(c) of the Act, section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1 or section 222(a) of the Social Security Amendment of 1972 (42 U.S.C. 1395b–1 (note)) are permitted to change the order in which they allocate administrative and general costs to the order specified in the instructions for the Medicare cost report.

(2) For hospitals making this election, the base-period costs for the purpose of determining the per resident amount are adjusted to take into account the change in the order by which they allocate administrative and general costs to interns and residents in approved program cost centers.

(3) Per resident amounts are determined for the base period and updated as described in paragraph (e) of this section. For cost reporting periods beginning on or after January 1, 1986, payment is made based on the methodology described in paragraph (d) of this section.

(j) *Adjustment of a hospital's target amount or prospective payment hospital-specific rate*—(1) *Misclassified operating costs*—(i) *General rule.* If a hospital has its base-period graduate medical education costs reduced under paragraph (e)(1) of this section because those costs included misclassified operating costs, the hospital may request that the intermediary review the classification of the affected costs in its rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its rate of increase ceiling or prospective payment base year costs no later than 180 days after the date of the notice by the intermediary of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the

hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate or the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

(2) *Misclassification of graduate medical education costs*—(i) *General rule.* If costs that should have been classified as graduate medical education costs were treated as operating costs during both the graduate medical education base period and the rate-of-increase ceiling base year or prospective payment base year and the hospital wishes to receive benefit for the appropriate classification of these costs as graduate medical education costs in the graduate medical education base period, the hospital must request that the intermediary review the classification of the affected costs in the rate-of-increase ceiling or prospective payment base year for purposes of adjusting the hospital's target amount or hospital-specific rate. For those cost reports that are not subject to reopening under § 405.1885 of this chapter, the hospital's reopening request must explicitly state that the review is limited to this one issue.

(ii) *Request for review.* The hospital must request review of the classification of its costs no later than 180 days after the date of the intermediary's notice of the hospital's base-period average per resident amount. A hospital's request for review must include sufficient documentation to demonstrate to the intermediary that modification of the adjustment of the hospital's hospital-specific rate or target amount is warranted.

(iii) *Effect of intermediary's review.* If the intermediary, upon review of the hospital's costs, determines that the hospital's hospital-specific rate or target amount should be adjusted, the adjustment of the hospital-specific rate and the adjustment of the target amount is effective for the hospital's cost reporting periods subject to the prospective payment system or the rate-of-increase ceiling that are still subject to reopening under § 405.1885 of this chapter.

D. Subpart H is amended as follows:

Subpart H—Payment for End-Stage Renal Disease (ESRD) Services

§ 413.170 [Amended]

In § 413.170, paragraph (g)(3) is removed and reserved.

(Catalog of Federal Domestic Assistance program No. 13.773, Medicare-Hospital Insurance)

Dated: September 20, 1989.

Louis B. Hays,

Acting Administrator, Health Care Financing Administration.

Approved: September 25, 1989.

Louis W. Sullivan,

Secretary.

Editorial Note: The following Appendix will not appear in the Code of Federal Regulations.

Appendix

TABLE 1a.—UPDATE FACTORS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1985 AND BEFORE JULY 1, 1988

Cost reporting period	Update factor [1]
7/1/85 to 6/30/86	1.0100
8/1/85 to 7/31/86	1.0100
9/1/85 to 8/31/86	1.0100
10/1/85 to 9/30/86	1.0100
11/1/85 to 10/31/86	1.0100
12/1/85 to 11/30/86	1.0100
1/1/86 to 12/31/86	1.0100
2/1/86 to 1/31/87	1.0100
3/1/86 to 2/28/87	1.0100
4/1/66 to 3/31/87	1.0100
5/1/86 to 4/30/87	1.0100
6/1/86 to 5/31/87	1.0100
7/1/86 to 6/30/87	1.0146
8/1/86 to 7/31/87	1.0210
9/1/86 to 8/31/87	1.0303
10/1/86 to 9/30/87	1.0378
11/1/86 to 10/31/87	1.0386
12/1/86 to 11/30/87	1.0365
1/1/87 to 12/31/87	1.0393
2/1/87 to 1/31/88	1.0428
3/1/87 to 2/29/88	1.0436
4/1/87 to 3/31/88	1.0453
5/1/87 to 4/30/88	1.0453
6/1/87 to 5/31/88	1.0443
7/1/87 to 6/30/88	1.0405
8/1/87 to 7/31/88	1.0394
9/1/87 to 8/31/88	1.0393
10/1/87 to 9/30/88	1.0390
11/1/87 to 10/31/88	1.0389
12/1/87 to 11/30/88	1.0397
1/1/88 to 12/31/88	1.0413
2/1/88 to 1/31/99	1.0402
3/1/88 to 2/28/89	1.0417
4/1/88 to 3/31/89	1.0425
5/1/88 to 4/30/89	1.0425
6/1/88 to 5/30/89	1.0442

[1] The update factor for a specified cost reporting period is applied to the prior period's per resident amount and, for cost reporting periods beginning on or after July 1, 1986, accounts for the 12-month average change in the CPI-U ending at the midpoint of the specified cost reporting period.

Appendix

TABLE 1b.—PROJECTED UPDATE FACTORS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 1988, TO BE USED FOR INTERIM PAYMENT PURPOSES ONLY

Cost reporting period	Updated factor [1]
7/1/88 to 6/30/89	1.0416
8/1/88 to 7/31/89	1.0416
9/1/88 to 8/31/89	1.0416
10/1/88 to 9/30/89	1.0436
11/1/88 to 10/31/89	1.0436
12/1/88 to 11/30/89	1.0436
1/1/89 to 12/31/89	1.0453
2/1/89 to 1/31/90	1.0453
3/1/89 to 2/28/90	1.0453
4/1/89 to 3/31/90	1.0465
5/1/89 to 4/30/90	1.0465
6/1/89 to 5/31/90	1.0465
7/1/89 to 6/30/90	
8/1/89 to 7/31/90	
9/1/89 to 8/31/90	
10/1/89 to 9/30/90	
11/1/89 to 10/31/90	
12/1/89 to 11/30/90	
1/1/90 to 12/31/90	
2/1/90 to 1/31/91	
3/1/90 to 2/28/91	
4/1/90 to 3/31/91	
5/1/90 to 4/30/91	
6/1/90 to 5/31/91	

[1] The projected update factor for a specified cost reporting period is to be used for interim payment purposes only and is applied to the prior period's per resident amount. The actual update factor will be published in a future notice and is to be used for final settlement purposes. The projected update factors are based on estimates prepared for HCFA by Data Resources, Inc. on a quarterly basis. The forecasted percent changes in the CPI-U over the previous 12-month period serve as the proxy behind the All Other NonLabor Intensive portion of the hospital input price index used in the Medicare prospective payment system.

TABLE 2a.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1985 THROUGH JUNE 30, 1989

Specialties	Initial residency period
Medicine	
Allergy & Immunology	4
Diagnostic Laboratory Immunology	4
Anesthesiology	5
Colon and Rectal Surgery	5
Dermatology	5
Dermatopathology	5
Emergency Medicine	4
Family Practice	4
Internal Medicine	4
Cardiology	4
Endocrinology and Metabolism	4
Gastroenterology	4
Hematology	4
Infectious Disease	4
Medical Oncology	4
Nephrology	4
Pulmonary Disease	4
Rheumatology	4
Neurological Surgery	5
Nuclear Medicine	5
Obstetrics and Gynecology	5
Ophthamology	5

TABLE 2a.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1985 THROUGH JUNE 30, 1989—Continued

Specialities	Initial residency period
Orthopaedic Surgery	5
Otolaryngology	5
Pathology	5
Blood Banking	5
Chemical Pathology	5
Dermatopathology	5
Forensic Pathology	5
Hematology	5
Immunopathology	5
Medical Microbiology	5
Neuropathology	5
Radioisotopic Pathology	5
Pediatrics	4
Pediatric Cardiology	4
Pediatric Endocrinology	4
Pediatric Hematology-Oncology	4
Pediatric Nephrology	4
Neonatal-Perinatal Medicine	4
Physical Medicine/Rehabilitation	5
Plastic Surgery	5
Preventive Medicine	4
Psychiatry and Neurology	5
Child Psychiatry	5
Radiology	5
Nuclear Radiology	5
Surgery	5
General Vascular Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Urology	5
Osteopathy	
Aerospace Medicine	4
Anesthesiology	5
Angiography and Interventional Radiology	5
Cardiology	5
Clinical Allergy and Immunology	5
Dermatology	5
Diagnostic Radiology	5
Osteopathic Manipulative Medicine	3
Emergency Medicine	5
Endocrinology	5
Gastroenterology	5
General Practice	4
General Surgery	5
General Vascular Surgery	5
Hematology	5
Hematology/Oncology	5
Infectious Diseases	5
Internal Medicine	4
Medical Diseases of the Chest	5
Neonatal Medicine	5
Nephrology	5
Neurology	5
Neuroradiology	5
Neurosurgery	5
Nuclear Medicine	4
Nuclear Radiology	5
Obstetrics—Gynecology	5
Obstetrics & Gynecological Surgery	5
Occupational Medicine	4
Oncology	5
Ophthalmology	5
Orthopedic Surgery	5
Otorhinolaryngology	5
Otorhinolaryngology/Oro-Facial Plastic Surgery	5
Pathology	5
Pathology, Anatomical	5
Pediatrics	4
Plastic and Reconstructive Surgery	5
Proctology	4
Psychiatry, General and Child	5
Public Health and Preventive Medicine	4

TABLE 2a.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1985 THROUGH JUNE 30, 1989—Continued

Specialities	Initial residency period
Radiation Oncology	5
Radiological Imaging	5
Radiology	5
Rehabilitation Medicine	5
Reproductive Endocrinology	5
Rheumatology	5
Thoracic Surgery	5
Urological Surgery	5
Podiatry	
Rotating Podiatric Residency	2
Podiatric Orthopedic Residency	2
Podiatric Surgical Residency	2
Dentistry	
Dental Public Health	3
Endodontics	3
Oral Pathology	4
Oral and Maxillofacial Surgery	4
Orthodontics	3
Pediatric Dentistry	3
Periodontics	3
Prosthodontics	3
Prosthodontics Maxillofacial	4

TABLE 2b.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1989 [1]

Specialities	Initial residency period
Medicine	
Allergy & Immunology	4
Diagnostic Laboratory Immunology	4
Anesthesiology	5
Critical Care Medicine	5
Colon and Rectal Surgery	5
Dermatology	5
Dermatopathology	5
Emergency Medicine	4
Family Practice	4
Internal Medicine	4
Cardiology	4
Critical Care Medicine	4
Endocrinology and Metabolism	4
Gastroenterology	4
Hematology	4
Infectious Disease	4
Medicine Oncology	4
Nephrology	4
Pulmonary Disease	4
Rheumatology	4
Neurological Surgery	5
Nuclear Medicine	5
Obstetrics and Gynecology	5
Ophthalmology	5
Orthopaedic Surgery	5
Otolaryngology	5
Pathology	5
Blood Banking	5
Chemical Pathology	5
Dermatopathology	5
Forensic Pathology	5
Hematology	5
Immunopathology	5
Medicine Microbiology	5
Neuropathology	5
Radioisotopic Pathology	5
Pediatrics	4
Pediatric Cardiology	4
Pediatric Endocrinology	4
Pediatric Hematology-Oncology	4

TABLE 2b.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1989 [1]—Continued

Specialities	Initial residency period
Pediatric Nephrology	4
Neonatal-Perinatal Medicine	4
Physical Medicine/Rehabilitation	5
Plastic Surgery	5
Preventive Medicine	4
Psychiatry and Neurology	5
Child Psychiatry	5
Radiology	5
Nuclear Radiology	5
Surgery	5
Critical Care Medicine	5
General Vascular Surgery	5
Pediatric Surgery	5
Thoracic Surgery	5
Urology	5
Osteopathy	
Aerospace Medicine	4
Anesthesiology	5
Angiography and Interventional Radiology	5
Cardiology	5
Clinical Allergy and Immunology	5
Dermatology	5
Diagnostic Radiology	5
Osteopathic Manipulative Medicine	3
Emergency Medicine	5
Endocrinology	5
Gastroenterology	5
General Practice	4
General Surgery	5
General Vascular Surgery	5
Hematology	5
Hematology/Oncology	5
Infectious Diseases	5
Internal Medicine	5
Medical Diseases of the Chest	5
Neonatal Medicine	5
Nephrology	5
Neurology	5
Neuroradiology	5
Neurosurgery	5
Nuclear Medicine	4
Nuclear Radiology	5
Obstetrics—Gynecology	5
Obstetrics and Gynecological Surgery	5
Occupational Medicine	4
Oncology	5
Ophthalmology	5
Orthopedic Surgery	5
Otorhinolaryngology	5
Otorhinolaryngology/Oro-Facial Plastic Surgery	5
Pathology	5
Pathology, Anatomical	5
Pediatrics	4
Plastic and Reconstructive Surgery	5
Proctology	4
Psychiatry, General and Child	5
Public Health and Preventive Medicine	4
Radiation Oncology	5
Radiological Imaging	5
Radiology	5
Rehabilitation Medicine	5
Reproductive Endocrinology	5
Rheumatology	5
Thoracic Surgery	5
Urological Surgery	5
Podiatry	
Rotating Podiatric Residency	2
Podiatric Orthopedic Residency	2
Podiatric Surgical Residency	2
Dentistry	
Dental Public Health	3

TABLE 2b.—INITIAL RESIDENCY PERIOD LIMITATIONS EFFECTIVE JULY 1, 1989 [1]—Continued

Specialities	Initial residency period
Endodontics	3
Oral Pathology	4
Oral and Maxillofacial Surgery	5
Orthodontics	3
Pediatric Dentistry	3
Periodontics	3
Prosthodontics	3
Prosthodontics Maxillofacial	4

[1] The changes from Table 2a, which applies to cost reporting periods beginning on or after July 1, 1985, through June 30, 1989, are as follows: Critical Care Medicine is added as a subspecialty in three specialties—Anesthesiology (5), Cardiology (4), and Surgery (5); Osteopathic programs in Emergency Medicine are increased to 5; Osteopathic programs in General Practice are increased to 4; and Dentistry programs in Oral and Maxillofacial Surgery are increased to 5 years beginning July 1, 1989.

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